HOSPITAL NURSES' ATTITUDES TO WORK: A CASE STUDY OF A CHINESE HOSPITAL

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This work or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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Abstract

The aim of this study is to explore what the relevant factors of nurses' attitudes to and at work are. These include the separate but related hypotheses – the nature of the profession and changes in terms of management and training; the nature of the work situation including contracts and pay determination; and the nature of work relations as they impinge on nurse status including relations with co-workers and patients. All of which can be understood and compared with other workers in terms of both labour process and industrial relations as Goldthorpe (1968) did in the study of car workers. In the context of the contemporary Chinese social and political economy, the research also evaluates the roles of the government and how it affects nurses' attitudes to the profession. It is grounded in a case study of 330 nurses in a Chinese public sector hospital, using questionnaires, interviews, and documentary evidence on government policies and hospital practices. The findings suggest that nurses at the case study hospital are frequently put under pressure due to the high number of patients they are expected to care for. This was caused by insufficient government funding for public sector hospitals, and the pressure to improve overall efficiency within the health service. The use of different types of employment contracts for nurses has caused strong resentment among nurses because it fails to award 'equal pay for equal work'. In addition, the current system used in many Chinese hospitals for nurse education, recruitment, training and development, and pay have not helped establish realistic expectations of nursing or rewarded nurses for the work they do effectively.

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List of Abbreviations

ACAS	Advisory, Conciliation and Arbitration Service
ACFTU	All-China Federation of Trade Unions
ASHE	Annual Survey of Hours and Earnings
BMISUE	Basic Insurance Scheme for Urban Employees
CCP	Chinese Communist Party
CIPD	Chartered Institute of Personnel and Development
COEs	Collective-Owned Enterprises
DfES	Department for Education and Skills
DPEs	Domestic Private Enterprises
EEA	European Economic Area
GDP	Gross Domestic Product
HCAs	Health Care Assistants
HRM	Human resource management
IDS	Income Data Services
IFS	Institute for Fiscal Studies
IiP	Invest in People
IWPR	Institute for Women's Policy Research
LRD	The Labour Research Department
MOF	Ministry of Finance, China
MOH	Ministry of Health, China
MOP	Ministry of Personnel, China
NAs	Nursing Assistants

NHFPC	National Health Commission of the People's Republic of China
NHS	The National Health Service
NMC	Nursing and Midwifery Council
NMW	National minimum wage
NPM	New Public Management
NVQs	National Vocational Qualifications
OECD	The Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
PBR	Payment by Results
PRBs	Pay Review Bodies
PRC	People's Republic of China
PRP	Performance Related Pay
RCN	Royal College of Nursing
RMB	Renminbi
SOEs	State-Owned Enterprises
SPEs	State-owned Enterprises
UK	The United Kingdom
URBMI	The Urban Resident Basic Medical Insurance
USA	The United States of America
WERS	Workplace Employment Relations Study

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Chapter One

Introduction

The purpose of this study is to answer this question: what are the relevant factors of Chinese public sector hospital nurses' attitudes to and at work? These include the separate but related hypotheses -- the nature of the profession and changes in terms of management and training, the nature of the work situation including contracts and pay determination and the nature of work relations as they impinge on nurse status including relations with co-workers and patients. All of which can be understood and compared with other workers in terms of both labour process and industrial relations as Goldthorpe did in the study of car workers. These hypotheses will be tested through questionnaires completed by nurses, and semi-structured interviews with nurse managers and hospital management.

The approach of this thesis is based on Goldthorpe's (1968) model when he looked at the relationship of car workers to their working lives. In particular he sought to both describe the total set of relationships as well as to explain the emergence of instrumentality. As he explains "The primary aim of this monograph is descriptive: to give some account of the attitudes and behaviour of a sample of 'affluent' manual workers in the context of their industrial employment. A secondary aim is theoretical: to examine how the attitudes and behaviour in question can best be explained and understood" (p.1). Their ground-breaking study brought together developments in labour process (Braverman, 1974) with its commentary on modern Taloyrism

alongside the traditional industrial relations emphasis on job regulation (Clegg, 1971; Flanders, 1975). This itself was a development from Goodrich's (1920) conceptualisation of work as a 'frontier of control'. Goldthorpe studied industrial workers in their work and home setting in order to examine the relationship of employment status, class situation, and attitudes to managers and trade unions. Using relatively 'affluent' car workers in Luton he focussed on their relationships at work with co-workers, line managers, union representatives, and with work tasks themselves. This combined an awareness of context and power relations with issues facing all workers of pay, performance management, and the wage-effort bargain. His methods and analysis lend themselves to replica studies of other workers in other settings. This thesis uses his general approach to examine the working lives of Chinese nurses based on their workplace interactions with colleagues, managers, and patients as well as how they feel about their pay, their line managers, and their job.

This study therefore develops the themes associated with managerial changes to professional job autonomy among public sector workers, such as teachers (Carter and Stevenson, 2012); lecturers (Mather and Seifert, 2014); and nurses (Bach, Kessler Heron, 2012). Most of these studies found significant pressure on job autonomy through the mechanism of pay systems, shifting targets, achievement, and performance management. It is important to note the full extent of the employment relationship, as it is not only a relationship between managers and workers, but between co-workers, and with users/patients. In this sense, my study seeks to show a growing

alienation amongst Chinese nurses with regard to the relationships with patients, co-workers and managers, and this is made concrete in labour process terms through changes in their pay, other terms and conditions, and their attitudes to their profession. This research will look at the relevant concepts, such as job regulation, perspectives (Heery, 2016a; Dundon *et al.*, 2015) and the ways in which Taylorism is altering the labour process (Blake and Moseley, 2011; Huang *et al.*, 2013).

The next chapter looks at issues around the management of nurse labour. It begins with an examination of the labour market with the emphasis on the buying and selling of a quality and quantity of labour time (Manning, 2003; Freeman, 2005; Crouch, 2011; Ackers, 2012; Johnstone, 2015). How the labour market and state regulation determine the general level of relative wages and how the payment system inside the organisation is used to determine the exact earnings for employees. This is followed by the labour problem of relatively weak performance and the need for management to control worker performance. Scientific Management, also known as Taylorism believes that there is only best way of how the work is to be done and it views the worker as a 'rational economic man' (Zuffo, 2011; Paxton, 2011; Paton, 2013). The next section of this chapter assesses ways of solving the labour problem, including discussing the fundamental principles of employment relations, and its three perspectives, job regulation and the nature of professional work. Ways and means to control workers' performance are then discussed. The final section of this chapter offers a detailed account of the division of labour and the changes of the nursing role.

Discussions of the studies that look at the labour process of nurse work, nurse pay, management reforms and the management of nurse labour explain how this research takes an employee relations' stance with the emphasis on nurse attitudes towards their pay and conditions of service; their management; their colleagues; their patients; and their tasks and task allocation. This chapter ends with a discussion of nursing relationships, including nurses and patients, and nurses and their co-workers.

Chapter Three then sets the scene of the case study. With a focus on nurses at work and the related labour issues, it introduces the changing landscape of industrial relations in China, Chinese pay determination process, Chinese health reform and Chinese health service personnel management. It provides a general account of the case study hospital, such as the size of the hospital, and the number of staff. This information provides a sense of the scale of the case study hospital, including its performance in relation to hospitals in China. Thus further sets the scene for the case study in the later chapters.

Before presenting the findings of this research, Chapter Four considers the theoretical perspectives and methods which have shaped this thesis. This research has adopted the methods used by Goldthorpe including semi-structured interviews and field investigation, as well as questionnaires as a key data collection method. Some issues and challenges arose during the design, collection and processing stages of the research, and they are discussed. A detailed account of the fieldwork is provided in this chapter

before attempting to explain the validity and reliability of the data, and the rationale behind choosing the methods used.

The next two chapters present the questionnaire findings along with the interview findings with the departmental head nurses and the case study hospital management team. Chapter Five focuses on findings relating to Chinese nurses' working lives, including their attitudes to patients, to co-workers, to management and to the nursing profession. Chapter Six explores factors that affect nurses' attitudes to their work, particularly around attitudes to their terms and conditions of work, including pay and bonus scheme, job evaluation, training, and career development.

The final chapter summarises the thesis and provides an overall conclusion to the study. It revisits the issues set out to explore at the beginning of the thesis and goes on to address findings and problems identified through this study. It highlights the similarities of this study to Goldthorpe's study of car workers' attitudes to their working lives. It argues that nurses, like any other professions, despite the quality of the work and status of the profession, are fundamentally paid workers that are subject to management control, and exhibit all the characteristics of other workers.

Chapter Two

The management of nurse labour

2.1 Introduction

This chapter uses predominately UK literature to provide a detailed account of the issues around the management of nurse labour. There are two main reasons for employing UK literature for a study looking at Chinese nurses. Firstly, a worker is a worker regardless of nationality – issues around a worker's work in China are no different to that of the UK, this makes using UK literature for this study relevant. Secondly, there are very few studies examining issues of Chinese nurse labour which leaves significant research gaps in this area. On the contrary, a relatively larger amount of literature can be found on the study of UK nurse labour, which this study relies on.

This chapter will start with an examination of the labour market with the emphasis on the buying and selling of a quality and quantity of labour time (Manning, 2003; Freeman, 2005; Crouch, 2011; Ackers, 2012; Johnstone, 2015). It discusses how the labour market and state regulation determine the general level of relative wages and how the payment system inside the firm is used to determine the exact earnings for employees. Labour markets, both external and internal, affect the control of the job (Brown, 2009). This is followed by the labour problem of relatively weak performance and the need for management to control worker performance. Scientific Management, also known as Taylorism believes that there is only best way of how the work is to be done and it views the worker as a 'rational economic man' (Zuffo, 2011;

Paxton, 2011; Paton, 2013). This will lead to a discussion of how scientific management, human relations, and human resource management help promote employers' interests through looking at the purpose and the function of management. The next part highlights the concerns over work itself, through a discussion of the labour process theory, and job autonomy.

The next section attempts to look at ways to solve the labour problem. It starts with an introduction Goldthorpe's study on industrial relations, followed by a discussion of the fundamental principles of employment relations, and its three perspectives. It is important to fully understand the objectives of HRM before debating the best method of achieving them. The purpose of HRM and the three perspectives, Unitarism (Loher *et al.*, 1985; Warren, 1996; Ackers and Wilkinson, 2003; Grimshaw and Rubery, 2007; Proctor, 2008; Lazear and Gibbs, 2009; Spencer, 2009), Pluralism (Fox, 1966; Ackers and Wilkinson, 2003; Kaufman, 2004, 2014; Cradden, 2014; Heery, 2016b) and Marxism (Hyman, 1975; Gilbert, 1986; Kelly, 1988, 1998; Wright, 2010) will be reviewed. It then looks at the purpose of HRM, including the sections on the special case of industrial relations in the public sector. The relationship between unitarism and HRM is also discussed, as HR managers tend to take unitarist positions.

The next part dives into job regulation and its ways and means to control workers' performance is discussed. It provides a detailed discussion of job regulation and rules concerning controls over work itself. A thorough understanding of job regulation, especially unilateral job regulation, plays an

important and direct role in workers' rights to work, which also affects the ways in which HR managers try to manage their workers and make use of their labour efficiently based on these rules. In the context of this research, job regulation plays a crucial role in determining the manager's rights to manage. This section ends with a comment on the nature of professional work.

This is followed by a discussion on the ways and means to control workers' performance. It starts off with a detailed account of pay and conditions of service, followed by discussions of other ways that could control and affect workers' performance, including types of bonus, trade unions and collective bargaining, training and development. Pay is an important element in employment relations. For employers, pay is an inevitable labour cost, and pay is workers' main source of income. How the labour market and state regulation determine the general level of relative wages and how the payment system inside the firm is used to determine the exact earnings for employees are discussed. The neo-classical theory of the firm is based on the free mobility of labour in the labour market, which is affected by the supply and demand of labour. However, other factors do have influence on relative wage. Trade union bargaining can change workers' pay; and wage levels are not only influenced by labour market, but also intervened by direct and indirect state regulation.

Pay is also the central issue in respect of management control, which is indicated in the way in which pay is regulated. Grading systems and

structures such as Performance-Related Pay (PRP) can be used by managers to better regulate workers' pay through linking it with their performance or output. This eventually raises the question of employers gaining control over workers. Different organisations have different wage levels. This thesis will show how the labour market and state regulation determine the general level of relative wages at first.

The final section of this chapter offers a detailed account of the division of labour and the changes of the nursing role; nurse labour and how nursing roles have evolve from boundaries between the work of nurses and doctors to the potential for divisions within nursing. Discussions of the studies that look at the labour process of nurse work, nurse pay, management reforms and the management of nurse labour explain how this research takes an employee relations' stance with the emphasis on nurse attitudes towards their pay and conditions of service; their management; their colleagues; their patients; and their tasks and task allocation. This chapter ends with a discussion of nursing relationships, including nurses and patients, and nurses and their co-workers.

2.2.1 Labour Markets and wage theories

Employers recruit and select employees from labour markets (Manning, 2003). Workers come from both weak and strong labour markets and they usually receive different rewards. If relevant skills are plentiful, the organisation has the choice of whether, and to what extent it wishes to develop staff internally. However, if skilled workers are in short supply and

the labour market is tight then internal development invariably gets prioritised (Freeman, 2005; Ackers, 2012). The external labour market undoubtedly has a big impact on employers' development strategies and it affects the integration of human resource strategy with the overall organisational strategy. Recruitment and selection is constrained by labour market circumstances. Skills shortages are likely to lead to pay increases. Organisations vary in sizes and set different goals, and therefore have different recruitment objectives from the labour markets. This means changes in structure and content of labour market will have an impact on management's decisions. Certain professions have their own organisations that have control over the people within the profession. These organisations do not belong to any government bodies, they are independent, have their own rules, and they aim to protect workers within the industry (Manning, 2003).

Unilateral job regulation and the unitarist perspective together are part of what makes HRM a management approach to solving labour problems, namely low productivity (Freeman, 2005). HRM manages business through laying out a series of rules of the detailed practice of business operations. Workers are employed by employers based on a contract; they sell their labour and therefore get paid. According to Taylor's (1947) theory, workers dislike work, and always tried to avoid work because of their inherently lazy nature, so an efficiency reward strategy is important. Therefore, there is a direct link between workers entering the labour market seeking wages as income in exchange for work, and the subsequent management of that work

on the basis of the exercise of managerial authority over the subordinate class of workers.

The labour market is affected by a number of things: the general level of economic activity, changes in the level of unemployment, technological change, and the number of people willing to work and seeking work (Crouch, 2011). If there are many people looking for a job in the market, then it is much easier for employers to find workers than when there are fewer people looking for jobs. If the supply is greater than demand, then employers will have full control of the workers, workers do not have a choice apart from accepting management's right to manage. Employers who make decisions unilaterally will offer lower pay, fewer rights and worse terms and conditions, but workers will still take the offer simply because there are more people looking for jobs than positions available. If they do not want to take the job, someone will, so employers have complete control over labour (Freeman, 2005; Johnstone, 2015).

The income of labour is all income earned from a worker no matter if it comes in the form of wages or salaries, and later pensions and benefits (Edwards, 2011). Employers set mechanisms for determining rates of pay for different jobs in all organisations. Relative wage rates are a substantial and sustained issue which is influenced by many factors such as labour skill, job essence, and discrimination. Instead of the pure supply and demand in the labour market, which leads to the fluctuation of pay between occupations, companies and gender, it is common that different wages are paid to

individuals doing the same job in the labour market; and there are wage differences between different occupational groups (Lipsey, 2007). The general model of pay determination mixes labour market pressures with government intervention and internal firm policies.

Pay determination is defined as 'the process of discovering those wage rates and related terms of employment, which the employer will make available and at which employees will work in the immediate future' (Taylor, 1957, p.84). Taylor argues that this process will ensure 'a validation of the terms of employment by a negotiated agreement between employees and employers who possess what is termed an "equality of bargaining power"' (*ibid.*). State policy and legislation can also affect wages and pay determination. Government can impact on the general level of wages by legislating for a specific minimum wage, which defines the lower wage rates that may legally be paid (Heery *et al.*, 2011). This simply means that minimum wage is regulated by law, managers cannot determine pay arbitrarily. Government may also intervene in employment relationship to influence wage inflation through initiatives introduced in the public sector (incomes policies) and by encouraging certain types of compensation such as profit sharing or share option schemes (Crouch, 2011; Stewart, 2011, Manning, 2011).

Rothschild explains that classical economics including the subsistence pay theory in which the long-term pay levels were to satisfy the conditions for maintaining workers and their family, emerged during the late 18th and early 19th century. The "Iron law of wages" theory means the inevitability of low

subsistence wages over a worker's life time (1954, p.8). Relative wages are determined by the quantity of money and the demand for it, as well as by the supply and demand of goods and services (Heery *et al.*, 2011). The population is a given factor that determines the supply of labour during a short period of time, whereas, in the long run, pay tends to be fixed at the minimum subsistence level (Dunlop, 1957). Another classical explanation, the wage fund theory, considers that wages are based on demand and supply, and that "the demand for wage-paid labor was a fixed amount consisting of the fund (whether money or a store of consumer goods was not too clear), set aside each year by employers for wage payments to labor" (Lester, 1964, p.274). This suggests that the national wage level is determined by the total supply of labour as the demand for labour during a short period of time is fixed (*ibid.*).

Marxists, however, focus more on the social relations behind the pay determination process. Marx disagrees that the real value of labour is the payment made to workers, he says:

"what economists therefore call value of labour, is in fact the value of labour-power, as it exists in the personality of the labourer, which is as different from its function, labour, as a machine is from the work it performs … …they never discovered the course of the analysis had led not only from the market-prices of labour to its presumed value, but had led to the resolution of this value of labour itself into the value of labour-power" (Marx, 1889, p.504).

Marx believed that the inequality between the value of labour and labour power reflects how workers are exploited by capitalists. Hyman argues that "the surplus value is taken by the small minority who own the means of production; … The control of this minority over the productive system necessarily carries with it the control over those whom they employ" (1975, p.22). He outlines how employers can manipulate pay, as the price of labour, to reduce their costs. Marx additionally pointed out that classical economics is uncritical and did not define the relationship between wages, profits and individual prices. He says that "the value of labour-power is determined, as in the case of every other commodity, by the labour-time necessary for the production, and consequently also the reproduction, of this special article" (Marx, 1889, p.167). Crucially Marx did not see labour the same as other commodites because of the social elements that come with employment.

In contrast neo-classical economists developed marginal productivity theory as "one of the most widely held wage theories since the late 19th century". This theory is also referred to as the "orthodox wage theory" – it believes that the market exchange applies to the exchange of labour, and pay determination is influenced by marginal productivity and market equilibrium (Lester, 1964, p.274). This means the money wage level changes are determined by "imbalanced aggregation between labour supply and demand", but the theory fails to address that "the actual wage will depend on the relative bargaining power between employer and employees" (Wood, 1978, p.5). Traditional neo-classical wage theory was based on a free exchange economy framework. Its method is largely related to a competitive

market where an equilibrium price allows all mutually beneficial trading opportunities to be fully realised (Nolan and O'Donnel, 1995, p.415). Therefore, marginal productivity theory defines the pay determination process by claiming that "once a general real equilibrium was established, the quantity of money determined the price and money wage level" (*ibid.*). Neo-classical pay theory believes that "workers' individual differences in tastes, ability and opportunities for skill acquisition" that pay differentials reflect relative job desirability (Gintis, 1986, p.71). Neo-classical theory is adopted by countries that believe in no-liberalism, and neo-liberal government policies do not tend to intervene in the labour market. They encourage the free operation of the labour market (Roche, 1997; Gumbrell-McCormick and Hyman, 2013).

The Chinese nurses' labour market will be discussed later in this research. The finding will also help explore public sector wage determination processes in China, in particular how nurses' pay is determined and the roles of hospital management, supply side, and both central and local government in the process.

2.2.2 Labour management

Management sees "the primary purpose of industrial relations is to support its strategies aimed at maintaining efficient and effective operations and improving organisational performance" (Salamon, 2000, p.234). Management ultimately expects workers to be subordinate, loyal and productive; and that management use managerial methods to secure

productivity by practising policies like ‘stick and carrot’ to control workers (Harbison and Myers, 1959; Kelly, 2010).

Taylor was the founder of the body of ideas that became known, within his lifetime, as ‘scientific management’. Taylor separated the conception and execution of work (Evangelopoulos, 2011; Blake and Moseley, 2011) as he believed there is only one best way of how the work is going to be done; and workers must be selected and trained as management required (Zuffo, 2011; Pruijt, 2003). Taylor hated the waste of resources at work, especially the waste of time, he thought it was morally appalling. He called this ‘soldiering’. There are two forms of soldiering: first, “the natural instinct and tendency of men to take it easy, which may be called natural soldiering”, Taylor saw this kind of ‘soldiering’ by workers as a rational strategy. Second, “from more intricate second thought and reasoning caused by their relations with other men, which may be called systematic soldiering” (Taylor, 1947, p.30).

When managers give workers a certain period of time to finish a task based on their experience or just purely guessing, it might result in easy jobs, managers would then alter the times, but workers were never be that foolish as to finish their tasks too quickly so that they would be given less time next time, or more work (Wren, 2011; Paton, 2013). Taylor claimed that workers should not be blamed at all, if they decide together to make sure the maximum economic returns without having to work too hard. If this tendency of natural soldiering is increased by having a group of men together doing similar tasks and having the same standard of pay, even the best and the

fastest worker will eventually slow down when they realise the lazy worker gets the same pay but only does half of the work. Taylor believed that systematic soldiering is evil for both workers and employers. Managers assume how much a kind of work can be done within certain amount of time from their own experience (rule of thumb), which varies and changes all the time; and although they may have doubts if some tasks could be done quicker than they have been, but they seldom bother to force the workers to work faster (Tolsby, 2000; Prujit, 2003).

In order to counter such tendencies ‘functional foremanship’ was brought to make the worker responsible to first-line supervisors as Taylor thought it was vital to break the traditional foreman’s power. He recommended a ‘thinking department’, whose job is to gather information on tasks, watch the routing of materials, sub-assemblies in the factory, prepares job-order tickets for operatives, calculates the pay and disciplines. Taylor also developed a thorough time and motion study that involved the breakdown of all essential tasks. Workers’ work process is observed and the elements of sequence of the tasks are defined, operations that contribute nothing to the completion of the task will be eliminated, and the quickest ways of doing each element will be used in the reconstructed sequence, with the time allowed for resting, this will be the one best way to do the job. Finally, Taylor proposed that workers are selected based on their skill, physical ability and attitude; and that they will be trained as the management required. If a type of work is performed by a ‘first class man’, then this ‘first class man’ should get ‘a fair day’s pay for a

fair day's work'. He also suggested the output bonus scheme to motivate the workers as his conception of worker motivation was purely 'economistic'.

A 'scientific management' approach to labour management believes there is only one best way of how the work is going to be done, workers are to accept manager's right to manage, and any conflict is seen as pathological (Taylor, 1947; Blake and Moseley, 2011; Paton, 2013; Zuffo, 2011). Fox (1966, p.3) claims that the unitarism perspective has only one source of authority and one focus of loyalty, and the team analogy (we are all in it together) is often used as a motivator of obedience. Workers are not given a chance to decide how they are going to do their work; they just do what they are told as managers believe the one best way is the only path to maximize productivity. The unitarist perspective is aligned with unilateral (one-way) job regulation -- rules in this case are the method through which managers exercise their rights to manage. It is a one-sided creation and the enforcement of employment rules is carried out by managers acting on behalf of employers (Grimshaw and Rubery, 2007, Spencer, 2009). Scientific management uses unilateral job regulation to gain complete control of workers so as to accomplish its goal of improving productivity.

The individual worker's "personal ambition" could be used to stimulate effort, and Taylor suggested piece rating would get the maximum output, because for ordinary workers to be motivated requires nothing but 30% more pay than average (Taylor, 1912, p.26-27). Higher wages only meant high "with relation to the average of the class to which the man belongs" (Taylor, 1921, p.27) for

the workers to be motivated to maximise productivity. Employers' interests are to maximise profit through having high productivity and good management. High productivity brings out the best profit for employers, and good management seeks ways to use labour efficiently in order to ensure high productivity and efficiency (Blake and Moseley, 2011; Zuffo, 2011).

During the historical development of joint stock companies the relationship between owners and managers changed, and some of the elements that prevented growth and innovation were discarded in some areas. Nepotism, for example, was partly replaced by 'merit' when recruiting managers (Bellow, 2003, Mulder, 2012; Dickson *et al*., 2012), because firstly, with the managers' expertise and their separation from the shareholders' interests, they are freer to run the business in their own or sectional interests; and secondly, managers are also employees of the company who may have a shared interest with other employees in the survival of the business, which essentially means if a business fails, they would be in the same situation as other employees in the company. Thirdly, managers are seen as a separate group within the organisation, they have the authority to make decisions on behalf of the owners, and these decisions may clash with other employees' interests, they then comprise a 'buffer zone' between the conflicting interests of capital and labour within the organisation (Burnham, 1945).

'Employers' and 'managers' are two terms which are often wrongly assumed to be synonymous, 'employer' equally applies to a small business in which the owner of the business is the employer of labour; whereas in a large

company it equates with the name of the company and its legally registered status. Management is a process engaging in functions including planning, co-ordinating, organising, staffing, directing and controlling the various activities and resources of an organisation, and it is through this efficiency is ensured and relevant goals are achieved (Harbison and Myers, 1959, 1964). All the above functions could be performed by a single person, such as the owner of a small business; and in large organisations professional managers are hired to carry out these functions; ownership does not have to stay together with management, and management may be divided into different categories from line management to top management, depending on the nature of the business activity, the size of the organisation and the technology used (Frege, 2007; Kaufman, 2014; Purcell, 2014).

Managers expect three responses from their workers – subordination, loyalty and productivity (Harbison and Myers, 1959). In any industrial organisation, workers are expected to take orders from managers, managers are there to assign duties, tasks hoping to get satisfactory performance from their workers; therefore subordination is required, however it is not sufficient, it needs to be seen together with loyalty, because managers believe that work performance will be better if the workers are loyal (McGuire *et al.*, 2011; Garavan and Carbery, 2012). Employers are interested in maximising productivity, and in order to make the workforce produce efficiently, it might need more than just subordination and loyalty. Sometimes, through consultation and the sharing of managerial functions, employers give workers a sense of participation so as to improve productivity (Harbison and

Myers, 1959). Today, employers' rights are carried out by managers, law gives senior managers the right to manage, managers are seen as a socially distinctive category, as their expertise, knowledge and skills provide them the authority; management is more than just a high-talented manpower in a company but a bureaucratic hierarchy both of persons and relationships (*ibid*). But no matter what source of management derives its authority, management has to find ways to exercise its authority over employees in order to carry out its ultimate objective, which is to maximise profit through having high productivity and efficiency (Gray *et al.,* 2011).

In this research, I am going to look at how different working relationships, including relationships with co-workers, with management, with patients, and factors such as, pay and bonus schemes, training and career development may affect nurses' attitudes towards their daily work as well as their feelings towards the nursing career. Also, through looking into the case study hospital's pay policy and its bonus scheme, this study uncovers the reasons behind why they may not work as motivators to make workers work harder.

Unlike Scientific Management, Human Relations (Barkin, 1955; Davis, 1957; Adams and Butler, 1999; Warner, 2014) views workers as "social men" (Mayo, 1933, p.156). "It is known that an adult of insufficient social experience will not be merely socially maladjusted; he will also be found to be using inferior logical techniques" (Mayo, 1933, p.156). Mayo also suggested that adults generally have three responses to their surroundings – logical, non-logical and irrational. 'Logical' responses in this sense are those

of leaders; non-logical and irrational are those led exhibit either 'non-logical' behaviour or 'irrational' behaviour. Pareto (1916) observed that in any society, leadership falls into two types or elite – the governmental and the non-governmental, the latter includes the direction of all industrial and economic activities. He also pointed out that these leaders in Europe are often the aristocracies; however they do not last, and are replaced by people and families from a lower class. Human relations focuses on the work group (Getha-Taylor, 2010; Warner, 2014; Obedgiu, 2017), whereas Taylor's concentration was on the individual. Productivity or cooperativeness with management was thought to be compelled by the workers' role and status in a group. Industrial society was viewed as a shaky fabric, since the diversity and continual changes frustrated the workers' desire for intimacy, consistency and predictability. Workers are human beings, are individualistic, sociable with irrational and non-logical beliefs and attitudes, therefore need to belong.

Scientific management is seen as an aggregation of individuals while human relations recognised a complex social structure (Fox, 1966). Human relations is a class relation where management as an elite group are rational (Mayo, 1933). Supervisors are not only there to give leaderships, but to attend to workers' emotional needs, adjust workers' social needs to the technical organisation and to offer welfare schemes, so as to make the workers feel more attached and belonged, in order to reach the management's goal to maximise profit (Busse *et al.*, 2016).

Scientific management, human relations and human resource management are three management theories which can be used as tools help organisations maximising their profits (Obedgiu, 2017). As discussed earlier, employers' interest is to maximise its profit through having high productivity and good management. Bach (2005, p.12) pointed out "by contrast mainstream management ideology is essentially Unitarism, in which management and the work force are viewed as sharing the same interests and any conflict arises from miscommunication". Scientific management believes there is only one best way of how the work is going to be done, workers are to accept managers' right to manage, and any conflict is seen as pathological. The unitarism perspective has only one source of authority and one focus of loyalty, team analogy is often used as an example (Loher *et al.*, 1985; Grimshaw and Rubery, 2007; Proctor, 2008; Heery, 2016a). Workers are not given a chance to decide how they are going to do their work, they do as they are told as managers believe the one best way is the only path to maximise productivity. The unitarist way of rule-making is unilateral; it is a one-sided creation and enforcement of employment rule made by employers. Scientific management uses unilateral job regulation to enforce complete powerful control of workers to accomplish its goal of improving productivity.

Although human relations and HRM both hold the unitarist view, they use bilateral job regulation to negotiate with their workers to gain complete trust, so that they are able to exercise their control. The reasons why HR managers benefit from taking a unitarist position are it is a method of self-reassurance, it is an instrument of persuasion and it is a technique for the

legitimation of authority. Unitarism expects everybody within the organisation to work together towards a common goal, each devotes themselves into what they do; it also wants to see all workers willing to accept leadership, are happy with what they do and how they do it. Workers are expected to accept rules that employer makes to suit their best interest. Rules about pay, working hours, holidays, health and safety, worker's rights and behaviours at work vary accordingly, but they do however affect management's control over labour. Managers believe that only through exercising the management's rights to manage will they reach the goal of maximising productivity and efficiency. Scientific management, human relations and human resource management use unilateral and bilateral job regulations to limit workers' rights, and to convince workers only through this will they benefit (Fox, 1966; Warren, 1996; Ackers and Wilkinson, 2003; Spencer, 2009).

HRM, therefore, has incorporated some of these elements of both Taylorism and Human Relations' approaches to labour management. It was mainly developed in the United States of America (USA) in the early 1980s as a reaction to several trends including the rising power of globally based multinational corporations, the failings of the USSR, the dominance of the USA economic model, the changes in technology (especially in communications) and the increased weakness of the labour movement in the form of both trade unions and traditional welfarist social democracy. Human Resource Management itself is defined as "a distinctive approach to employment management which seeks to achieve competitive advantage through the strategic deployment of a highly committed and capable

workforce, using an integrated array of cultural, structural and personnel techniques" (Storey, 1995, p.5). The meaning of HRM included an emphasis on pursuing a strategic approach to the management of human resources, developed with the full backing of senior management, embracing a tight coupling between human resources and business policy and a coherent or integrated set of personnel policies and practices (Bach and Sisson, 2000, p.11). Human resource managers are first concerned with ensuring that the business is appropriately staffed and thus able to draw on the human resources it needs. This involves designing organisation structures, identifying under what type of contract different groups of employees will work, before recruiting, selecting and developing the people required to fill the roles: the right people, with the right skills to provide their services when needed. Once the required workforce is in place, human resource managers seek to ensure that people are well motivated and committed so as to maximise their performance in their different roles (Hillange and Pollard, 1998; Boxall and Purcell, 2016).

Guest (1987) identified four HRM policy goals: integration; commitment; flexibility; and quality. Firstly, HRM is held to be distinctive from personnel management in so far as it puts a greater emphasis on the fit between employment policies and the overall business objective of the organisation. HRM is seen to consist of a mutually supportive and interlocking set of employment practices that, taken together, make an important contribution to the business goals. Secondly, the enhancement of individual employees' commitment to the organisation is central to the HRM approach. Thirdly,

HRM enables organisations to become more adaptable, principally by encouraging and reinforcing employment flexibility and thus the more effective utilisation of labour. Fourthly, it is assumed that the more elaborate approach to managing employees embodied by the HRM approach is more capable of delivering enhanced business performance.

It is argued that HRM intends to develop a strong, unitary, corporate culture, whereby organisational members share a commitment to values, beliefs, taken-for-granted assumptions that direct or reinforce behaviours considered conductive to organisational success. In any case, Human Resource Management is a unitary approach aimed at maximum utilisation of labour. HRM is regarded as a practical version of unitary management. From the unitarist perspective of view, workers have a shared objective with their employers, and employees must respect and obey management's decision, orders and rules. Therefore, the key of HRM is the way of controlling the employees and employers get the managerial autonomy at work (Legge, 2005; Delbridge, 2011).

Managerial autonomy is based on a unitarist point of view. The unitarism perspective has only one source of authority and one focus of loyalty, team analogy is often used as an example (Fox, 1966). Any conflict that may occur is seen as pathological. Scientific Management which believes that authority was a relationship which must be accepted by subordinate if it is to be effective also gives manages rights to manage. Although as Braverman (1974) considered scientific management ignores the complications

introduced because workers are necessarily human: personal needs, interpersonal difficulties, and the very real difficulties introduced by making jobs so efficient that workers have no time to relax. Mostly, managers today are now fully reconciled to Taylorism to negotiating terms and conditions in the labour market (Frege, 2007; Crouch, 2011). Managerial autonomy is also about unilateral job regulation, which is an important factor of HRM. Again, unitarist way of rule-making is unilateral. Rules in this case are the process of managers exercising their rights to manage. It is a one-sided creation and enforcement of employment rule made by employers. The relation between employers and employees is a relation between a bearer of power and one who is not (Kahn-Freund, 1977). Employees have the rights to fight for any kind of fairness or mistreat, but management, which takes the unitarist position does not allow divided loyalties, sources of authority or interests (Purcell, 2014); workers are expected to take what have been offered for the sake of their own interest (Lazear and Gibbs, 2009).

However, managerial autonomy is facing forces that limit managerial autonomy which come both externally and internally (Kaufman, 2014). The limits on managerial autonomy come from external constraints including law, labour market, and non-government organisations. There are a bundle of laws which have influences on the managers' prerogative, such as the regulations with regard to minimum pay, minimal age, duty of care, Health and Safety, equal opportunity, contract law and so on. Outside the company, autonomy is restricted by legal constraints, sometimes, in the form of discipline. There are lists of laws which are designed to restrict the

managers' behaviours, limiting the stretches of the autonomous activities for them (Crouch, 2011; Purcell, 2014).

2.2.3 Labour problem – labour process theory

It is argued that labour process analysis is "used by management studies to formulate more effective strategies of control through acknowledgement and incorporation of labour's subjectivity" (Tinel, 2009, p.12). Early labour process theory suggested that, in the capitalist way of production, workers derived power from their strategic location in the labour process (Kaufman, 2004). Braverman (1974) wrote that the traditional mode of production was controlled by workers' knowledge and their craft skills. Workers in manufacturing roles were particularly crucial in the manufacturing process because they had very high level of skill, and they were also able to use that demand higher wages and better working conditions. This induced the power struggle between employees and employers. Employees used this dynamic to maximise their positional power, and employers wanted to reduce employee power through changing control structures and job design (Heery, 2010; Reich, 2011).

Thus, new management theory such as scientific management divided work by breaking down skilled jobs, and separating the concept and execution of tasks. This resulted in workers no longer having control of a complete skilled labour process, as the more intellectual tasks of jobs were handed over to management. Braverman discussed how the principles of scientific management are essentially about how best to control waged labour as

Taylor “asserted as an absolute necessity for adequate management the dictation to the worker of the precise manner in which work is to be performed” (1974, p.62). These principles are, first, the labour process is detached from the skills of the workers; second, execution is largely separated from conception; and third, management uses its monopoly over knowledge by a “systematic pre-planning and pre-calculation of all elements of the labour process … to control each step of the labour process and its mode of execution” (Braverman, 1974, p.81-82.). The division of labour should not be seen as the existence of different jobs, but merely the simplifying and fragmentation of skills into smaller tasks, to cheapen and control the costs of labour.

Humans transform the material environment they live in as well as their own nature through labouring. Just like bees who also act upon the material world they live in. Though it is argued that what makes human labour special is the result at the end of every labour-process, already existed in the imagination of the labourer at the start of the labour process (Heery, 2016a). Value is always created by a labour process. Human production is oriented towards a purpose to which the labourer more or less consciously subordinates other purposes for a period of time. In the capitalist labour process, the person who carries out the labour work turns to work for the capitalist instead of for themselves. Labour subordinates to capital in this case and that will lead to changes in the organisation (Tinel, 2009). Marx considered the social and manufacturing divisions of labour distinct, and believed that both derive from the relations of production. Work should be organised in ways to ensure that

those carrying out the set tasks are to achieve them in a controlled manner especially when the service is provided to a group of set users and in the context of the *pro tem* business priorities. As discussed above, this division of labour and skill mix is intended to maximise productivity and minimise labour costs. Classical and neo-classical economists are interested in both the level of wages in exchange for labour and the use-value of that labour when managed to perform set tasks (Hicks, 1932). This general position allows growth of endless workplace conflicts between managers acting on behalf of the employer and workers hoping to defend and improve their pay and conditions of service (Kelly, 1999).

The distribution of work, who does what and how, for all production processes in society is a form of social division of labour which exists in all societies. The subdivision of work into its basic parts and the allocation of such work to different groups of workers in order to make the products is the manufacturing division of labour. Babbage (1832) believed that the division of labour enables employers or manufacturers to choose the exact skills needed for a job, and subsequently, uses division of labour as a way to cut wage costs. This is an incentive for employers to divide up the labour process - employers break down and simplify tasks through division of labour, they seek workers with readily acquired skills for each specific task, and plan ways for machines to replace human labour. This leads to a reduction in wages and an increase in the supply of labour force that are skilled for jobs. However, Babbage (*ibid*) argued that manufacturers proposed minute specialisation generally not for improving productivity but

for profitability. This struggle over job regulation is part of the wider class struggle to recognise the nature of exploitation and the efforts to hide it from workers (Hyman, 1989).

The argument is concluded, “as the division of labour increases, labour is simplified” (Marx, 1849, p.225). This becomes the basis for debates around an increasingly instrumental view taken by workers of their work (Goldthorpe *et al.*, 1968), namely that “they work for wages and that is that” (Marx, 1859, p.210). As labour diminishes into ever smaller skill differences the arriving of “generalised labour” creates a labour market ever more flexible and mobile to suit all occasions (Marx and Engels, 1846, p.87). As Cohen summarises, “capitalism increases the number of distinct jobs involved in the production of a given product, but at the same time it decreases the specialisation of the worker” (1988, p.194). Braverman’s general deskilling thesis (1974), and Polanyi’s (1944) interpretation of Gramsci’s works (1929-35) about the socialised nature of the division of labour and its attendant consequences for the creation of a working class as a class (Burawoy 2003) were all based on this.

Since the 1990s the argument has been widely extended to include workers, especially professional staff, in the public services. This also provides the basis to the case of the three emergency services in England where their budgets have been cut in real terms (ONS 2015), and subsequently staff pay and pensions (Hutton, 2011) have been reduced nationally by unilateral government decision (Mather and Seifert, 2017). It is also found that “in the

public services the connection between employee relations policies and practices, worker attitudes and behaviours, and organisational outcomes clearly assumes a very different form [from that in the private sector]" (Bach and Kessler, 2012, p.2). The key contrast between the United Kingdom (UK) public services and private profit-making sectors is that the public services are labour intensive and operate within non-market profitless organisations.

Public sector service managers, therefore, ought to identify ways of intensifying work as part of the process of 'managing' the labour problem (Burchell *et al.*, 2005). For example, the study of labour process changes in UK emergency services enabled the emergency services to be discussed within a framework of a new division of labour settlement that substitutes more management, more technology, and more outsourced work for traditional service standards.

As it is argued that the division of labour/skill mix decisions outcome vary dependent on particular management strategies, organised worker power, and workforce disposition (Vidal, 2007). One concern facing management in the decisions about task allocation to an understanding of the labour process of any occupation is the challenge of delivering savings and maintaining standards. This needs engagement with the nature of the tasks involved and level of skill required to perform the task so that people at the receiving end are assured. Gallie (1994) uses a number of measures for determining the skill shown in work such as length of training and time needed to learn to do the work well. However training and qualification do not in themselves

provide a clear explanation of job content or competence to carry out different tasks (Neyroud 2011). Therefore is it argued that the division of labour and task allocation decisions are not really about improving competence and service (Mather and Seifert, 2017), but about providing opportunities for cost savings as “separating simple from complex tasks permits economies in training and recruitment” (Rueschemeyer, 1986, p.18).

As Parker (2015) points out, division of labour is also division of knowledge. To help set a background of professional workers at work, it is essential to look at the labour process of a professional worker and how management reduces job autonomy in order to gain more managerial control. Thompson (2012, p.159) defines job autonomy as “the freedom to practice independently and to exercise professional judgment in practice activities” and it is “a central element for professional practice”. Many others have also written on a professional’s ability to work independently. Engel said that “autonomy is regarded as an important dimension of professionalism” (1970, p.12); while Freidson saw autonomy as a traditional element of professional work and subsequently referred to a profession as “an institution that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service” (1994, p.10). Scott (1998) pointed out, “one of the primary strengths of a full-fledged professional is that he or she is deemed capable of independent decision-making and performance, and this includes coordinating work with others as required by the situation” (p. 256).

2.3.1 Solving the labour problem - perspectives

This thesis follows Goldthorpe's 'Affluent Worker' model the aim of which was "to give some account of the attitudes and behaviour of a sample of 'affluent' manual workers in the context of their industrial employment, and to examine how the attitudes and behaviour in question can best be explained and understood" (Goldthorpe, 1968, p.1). Goldthorpe's study (1968) looked at the relationship of car workers to their working lives. In particular he sought to both describe the total set of relationships as well as to explain the emergence of instrumentality. This focus on the notion that workers work for wages and that is all (instrumentality) was designed to undermine the trend of management psychologists to enrich work through 'fake' initiatives. In particular the Goldthorpe studies sought to capture the entire work experience through interactions with others (managers, union reps, colleagues) as well as appreciating the impulse to make the best of one's working life through some commitment to the task in hand. This is even more important when studying groups such as nurses since their intrinsic professionalism can be enhanced and/or damaged by workplace relations as well as through the basics of pay and performance management.

In particular, he looked at the relationship between the worker and the job; the worker and the work group; and the worker and the firm. In terms of car workers' orientation to work, the central tendency was that they regarded work in a predominately instrumental way. Goldthorpe highlighted the difficulty in assessing the degree of workers' satisfaction with their jobs. He said "a man's work tends to be a more important determinant of his self-

image than most other of his social activities" (Goldthorpe, 1968, p.11). Workers choosing to remain in particular jobs show some degree of satisfaction with them, relative to other jobs that are available in the market. With regards to workers and their work group, there was a generally low "affective involvement" between workmates (Goldthorpe, 1968, p.53). Workers may set a relatively low value on close relationships with their co-workers even if it would not prevent the development of solidary groups; contrarily, workers would still retain contacts with certain fellow workmates even when they are dispersed and isolated in their work. As for workers and the firm,

> "attitudes towards job (in the narrow sense) and firm can, in certain cases, be quite sharply dissociated; that unrewarding and stressful work-roles need not lead to a generally negative orientation towards the enterprise as an employer; and conversely, that more rewarding or less stressful jobs are no guarantee that the organisation which is able to provide them will thereby gain workers' appreciation and attachment" (Goldthorpe, 1968, p.76).

Following this model, my study set out to examine Chinese public hospital nurses' attitudes towards their work. Within their work, attitudes have been divided into two parts: nurses' attitudes towards others, and attitudes towards the profession. The attitudes towards others section of this research mainly deals with the natural employee relationship that takes place when a worker enters the labour market to find work. As part of the way people exist in employment relationship, a worker not only has to interact with managers,

but also with co-workers, and users, which in this study means patients. The second part of this research deals with how the general industrial relations issues may impact nurses' attitudes to work and how they may affect the changes of nursing role. In particular, it looks closely to examine nurses' attitudes towards, pay and bonus, performance management, training and personal development, and career development. These combined, this research aims to examine how a Chinese public hospital nurse's attitudes towards patients, co-workers and management may affect their industrial behaviour.

Employment relations are the relationship between employer and employee and it may involve the interaction of employee representatives, trade unions, and the state (Crouch, 2011; Stewart, 2011, Manning, 2011). Employment relations has been described as a rule-making process which is concerned with different levels of analysis, with the employment relations and with substantive and procedural issues both collectively and individually and within union and non-union context (Dundon *et al.*, 2015). Market relations and managerial relations are the two parts in employment relations (Fox, 1966). In market relations, labour is like other commodities with a price (Fox, 1974). However, labour is embodied in workers, so it could be seen as a kind of human relations, which means the employer has to communicate with the workers so as to bring out the maximization of efficiency. Managerial relations are the relationship that define how this process takes place, like to stipulate a certain specific task, how much work is performed in that time (Bach and Winchester, 2003; Kaufman, 2014)

Employment relations are not an academic discipline in its own right, rather it is better conceptualised as a field of study. Early studies of employment relations were largely influenced by theoretical perspectives drawn from the discipline of economics (Clay, 1918; Robertson, 1961). Studies of employment relationship in specific contexts discovered that the characteristics of the external labour market could not adequately explain differences in wage levels (Brown and Nolan, 1988). Hence, there was an increasing emphasis on the way in which the institutions of job regulation, the bargaining role of trade unions in particular shaped employment relationships (Dunlop, 1958; Flanders, 1970; Clegg, 1976; Ackers and Wilkinson, 2003; Crouch, 2011). Fox, established a distinction between unitary and pluralist 'frames of reference' in employment relations, and articulated them as 'ideologies of management' (Fox, 1966, p.10). Namely, beliefs held by managers that influence their approach to employment relations. They can be likened to lenses, tools which people use to perceive and define social phenomena, in this case the nature of the employment relationship, and which thus influence and shape their actions (Fox, 1974).

The unitarist perspective has only one source of authority and one focus of loyalty (Warren, 1996; Ackers and Wilkinson, 2003; Grimshaw and Rubery, 2007; Proctor, 2008; Spencer, 2009). The team analogy is often used to explain this. Unitarism believes and expects everybody within an organisation to work together towards a common goal, each devotes themselves to what they do. It also hopes to see all workers accept leadership willingly, and that workers should be happy with what they do and

how they do it. No factions or dissent should be found within the team, every member should be completely loyal to their leaders. Unitarist perspective is seen as an ideology that justifies managers' unilateral decision-making. Workers should accept management's right to manage, because workers' disloyalty, disruption, and distortedness damage their own interests (Fox, 1966). Unitarism is there to cement an identity of interests between employer and employee. Any conflict that may occur is seen as pathological. Unitarist believes that if employees share the same interests and goals with their employers, there will be no conflicts, even if any conflict occurs, then it is caused by misunderstanding or mischief. Conflicts used to express employee's dissatisfaction and differences with management are perceived as an irrational activity and therefore should be suppressed through coercive means (Crouch, 1982; Spencer, 2009).

HRM practice has a strong unitary aspect and takes the managerial perspective as its reference (Guest, 1987; Legge, 2005; Delbridge, 2011). HR managers believe that with a harmony of interest, labour can be best and efficiently controlled and the maximising of profit can be achieved. HRM tries to convince workers that what they have been told is the right thing, and only by following the leadership will benefit themselves and everyone else. To a certain extent, it is necessary for managers to hold this view, and sometimes they can take it for granted that employees are willing to accept what they are expected to do because employees actually believe that if no shared interests are seen between them and their employers, no benefit will be received for either one of them.

It is debated that the reasons for managers to benefit from taking a unitarist position are it is a method of self-reassurance, it is an instrument of persuasion and it is a technique for the legitimation of authority (Boxall and Purcell, 2016). HR managers expect the workers to share their objectives so as to maximise the success of the company, they also expect workers to accept management's right to manage once they take up the job. Any disobedience may be seen as disloyal and disruptive (Hillage and Pollard, 1998; Boxall and Purcell, 2016). Unitarism assumes that those who cause trouble will be dismissed; employers offer training in communication skills to avoid miscommunication and personality clash; they also use laws to curb trade unions. Unitarism wants no disagreement or arguments which fit what managers ultimately want (Fox, 1966; Kelly, 2010; Ackers, 2012).

The principal assumption of the pluralist perspective is that the organisation comprises groups of individuals and that these groups have their own aims, interests and leadership. Pluralists allow for more than one source of authority, rival leadership, and expect divided loyalty among conflicting interest groups. It assumes that there are diverse goals and objectives that reflect different groups' interests within any organisation. It believes that conflicts are normal and will always show themselves. Whenever there are separate sources of authority there is the risk of conflict (Fox, 1966; Ackers and Wilkinson, 2003; Cradden, 2014; Heery, 2016a). Pluralist perspectives challenge Unitarist perspectives, because various organisations participate in determining the rules of employment compared with Unitarism management decision (Clegg, 1979).

Conflict is both rational and inevitable according to the pluralist perspective. Pluralism is a management position that recognises conflict as endemic, and is built into the employment relationship. Pluralist managers recognise that these conflicts exist and that they can only be resolved by the establishment and use of appropriate procedures. Pluralists accept trade union involvement; which means if employees are unhappy with their job for whatever reason, when there is high turnover, absenteeism or even sabotage, the trade union will then be dealing with employers on behalf of the employees in order to protect their rights, and will enable groups of employees to influence management decisions (Kaufman, 2004, 2010). Pluralism poses that 'problems' must be seen as structures and policies rather than as interpersonal struggles and clashes. Pluralist managers realise these conflicts, so they try to seek appropriate procedures to resolve them, and accepts divided loyalty and trade unions (sometimes) as a legitimate source of these loyalties. It then allows the involvement of both trade unions and collective bargaining (Fox, 1966; Kelly, 2010; Ackers, 2012).

Industrial relations to include HRM as the study of processes of control over work relations (Hyman, 1975). Marx conceives workers' grievances and aspirations should be placed in the wider social, economic and political context of modern capitalist society. He believes that conflict is inevitable. It assumes that conflicts are caused by different classes. The employer normally owns capital and buys labour time, while employees only have labour to sell. This imbalance of economic power will result in conflicts

between the managers and the workers. Marxism also assumes that conflicts of interests are normal and will always be there. Societal change is the result of class conflict, and without conflict, society will simply stop progressing; as inequalities in the distribution of economic power cause these conflicts, Marxism believes that conflicts cannot be avoided or eliminated.

Cohen (1988) argues Marxists have stressed the way that workers are compelled to work and therefore cannot be said to enter freely into an employment relationship. As a consequence workers are exploited and their weakness as individuals prompts them to collective organisation and action. In contrast, unitarists argue that workers are free to enter into contract and in doing so exercise market freedom. Marxists accept the pluralist view that conflict is inevitable in the industrial relationship, while it also argues that conflict is irreconcilable and is not resolved by collective bargaining and the intervention of parties.

HR managers try to control their workers' performance in order to maximise the profit. However, Marxism believes that it is natural for workers to pressure the employer for better wages and conditions in order to have better lives (Hyman, 1975); it is seen as the workers' rights to work. Marxism believes that the conflict between employer and worker will always exist, and the only solution is to struggle (Kelly, 1998; Wright, 2010).

Van Waardent (1995, p.11) states that industrial relations systems in many countries "have to a large extent been muddled by government action". The

state influences industrial relations policies especially when the state is the employer to those public sector organisations. The state also legislates and regulates the labour market. Government's political ideology is often reflected by the public sector and the degree of political control over the public sector is higher than that of the private sector (Corby and White, 1999). Through budget allocation, the state can influence employee relations practices (Corby and White, 1999, p.5) including "intervening in relationships between managements and workers, either directly, as with labour laws, or indirectly, for example with incomes policies" (Edwards, 1986, p.181). Beaumont (1992, p.16) sees it from a Marxist point of view that the structure and the functions of the state as a tool of the ruling class is largely shaped by the global requirement of capital, and it is designed to support the process of capital accumulation and capital legitimation. It is for this reason public sector industrial relations are usually led by the interests of the ruling political party's interests, in which the employees in the public sector, represented by trade unions, have an ongoing conflict of interest with their employers and the state.

As a direct employer, the state is involved in the direction and pattern of employment relationship within and outside the public sector. The state's way of dealing with industrial relations is directed by its own obligation to regulate the labour market and public expenditure. The state also has "a great interest in the workings of the labour market as the central authority in the economy" (Robertson, 1961, p.39). It is argued that employment is also a political issue so the state is expected to take responsibilities for "generating economic

growth and for providing reasonable job opportunities for citizens otherwise there will be political pressure" (Rubery and Grimshaw, 2003, p.2).

Under the same provision, temporary workers were also required to sign contracts. Depending on the type of organisation, there was a mix of permanent workers, contract workers and temporary workers in both State-Owned Enterprises (SOEs) and Collective-Owned Enterprises (COEs) (Ying, 1995). Also in the legal framework implemented in 1986, unemployment insurance was introduced for the first time; but not all employees automatically qualified for this insurance fund as Ying explains. According to Geng (1992), eligibility for unemployment benefit was conditional on having been employed for over five years, and benefit amounting to 50 to 70% of the standard wage was payable for twenty-four months; for those employed for less than five years, a similar benefit was payable for twelve months. This was seen as an improvement of unemployment benefits. Evidence found in studies over the decades have shown that public sector workers across the board experience relative low pay in exchange for better conditions and pensions, especially those in the NHS and local government (Thornley 1998; Thornley 2006).

2.3.2 Solving the labour problem – job regulation

We live in a rule dominated society. Our lives are somehow governed and limited by various kinds of rules — of language, behaviour, action and thinking. When we go to work, these rules then become the ones that regulate our jobs, in terms of what we do, how we do it, where to do it, how long do we work, and how much to be paid for. So job regulation refers to the

rules that govern the content of the employment relationship, the behaviour and activities of both employers and employees (Hyman, 1987, 2005). The main objective for HRM is to maximise efficiency and productivity, which means that it needs to have a full control of the labour in order to make the best use of it, but to achieve that goal, we need to know what the rules are, who make them and how they are enforced, and its impact on employment relations (Kaufman, 2010; Ackers, 2012).

Both internal and external job regulation affect employment relations. Internal job regulation has been pushed forward by different forces to answer different needs. The principal drive has come from management seeking to bring the work behaviour of employees under greater control (Flanders, 1965). Managers make rules in the interests of the collective of the organisation, and they are authorised to run business according to its agreed objectives. Workers are expected to accept the rules that each employer makes which suit their best interest. Rules about pay, working hours, holidays, workers' health and safety, workers' rights and behaviours at work could vary according to organisations; but they do however affect management's control of labour (Kelly, 2010).

Flanders believed that external job regulation were required to fix minimum or standard rates of pay, to limit working hours, and to reduce the worst physical hazards of industrial employment (1965). External job regulation, such as law and organisations for certain occupations also affect management's right to manage. Law in this case is seen as a kind of rule to

standardise organisations, whereby states make law to enforce its power to discipline employers (Gold, 2009; Manning, 2011; Stewart, 2011). Decisions made by management on how much workers get paid and how many hours they can work are regulated by law. This often limits and changes the way management may wish to manage despite profit maximisation being sacrificed (Fernie, 2011; Locke *et al.*, 2013).

Every day we go to work at a certain time, set by our employer, this is a rule that we obey. In different societies, with different cultural background, people are expected to behave according to its customs and traditions. Management, therefore, is expected to adapt the way it manages employees accordingly (Kelly, 2010; Kleiner and Krueger, 2010; Williams *et al.*, 2011).

Rules can be made unilaterally and bilaterally. Rules in this case are when managers exercise their rights to manage. It is a one-sided creation and enforcement of employment rule made by employers. Workers in the labour market may have the right to decide whether or not to accept management's right to manage before they take the job, but once they start the job, it means they have agreed to enter the contract which management has made on their own to assist them having a near complete control of workers so as to accomplish its goal (Grimshaw and Rubery, 2007, Spencer, 2009).

Kahn-Freund argues that the relation between employers and employees is a relation between a bearer of power and one who is not. Employees have the rights to fight against any kind of unfairness or mistreatment, but

management, which takes the unitarist position, does not allow divided loyalties, sources of authority or interests; workers are expected to take what have been offered for the sake of their own interest (1983, p.18).

Bilateral rule-making involves not only employers but also representatives of workers, including trade unions through collective bargaining. Pluralism holds the view that conflicts do exist and that is why pluralists believe getting both employers and employees sitting at the same table to make rules may lessen conflicts (Robinson and Wilson, 2006; Green and Heywood, 2011). Management aims to fully control labour by limiting workers' rights so unions fight to protect workers' rights. Bilateral job regulation seeks to eliminate conflicts by getting both sides involved to make a joint regulation (Williams *et al.*, 2011). In the UK, with the increasing concern over individual conflict at workplace, alternative methods of dispute resolution, such as the Employment Tribunal system, and the activities of ACAS (Advisory, Conciliation and Arbitration Service) helps to deliver in resolving individual employment disputes (Dickens, 2000; Knight and Latreille, 2000; Latreille *et al.*, 2012).

In this research, I will explore if the nurses think they are given the rights to accept management's rights to manage and that they are not forced to accept manager's unilateral rules. I will also discuss if the nurses are involved in any job decision making process and that they are given the chance to voice their opinions.

2.3.3 Professionalism – training and development

As has been argued, Taylor believed that it was crucial to expand managerial control over work in order to improve efficiency and productivity. It is argued that Taylorism increased capitalist social control rather than efficiency; and that Taylorism reduced employer dependence on workers' skill because work control is shifted to managers (Edwards, 1979). March and Simon (1958) say that both the managers and workers decisions can be programmed or bounded by rules. They believe that there is a large amount of leeway in the extent to which decisions are programmed, and both managers and workers are subjected to similar rules of work control. Dobbin and Boychuk claim individuals with good innate ability, education, and experience are most productive, and these workers are usually highly paid, "because salaries are based on productivity, and they will carry the highest levels of autonomy, because the value of human capital assets lies in scarce skills and the ability to make independent judgements" (1999, p.269). Jimenez-Jimenez *et al.* (2013, p.31) argue that autonomy is also closely related to knowledge management and many studies provide evidence that "autonomy increases employee intrinsic motivation to share knowledge".

According to Edwards and Gilman, efficiency wage theory "holds that paying wages above the competitive level may induce increased productivity from workers while also reducing workers' propensity to 'shrink'" (1999, p.22). Grimshaw and Rubery say that efficiency wage theory would need to explain why women are more likely to be in low-paid jobs, "this logic implies that effort and performance in [female-dominated] caring occupations are easier

to monitor than in male-dominated production jobs" (1995, p.119). Rubery (1997) argues theories including efficiency wage theory were set out to explain wage hierarchies in terms of the need to motivate worker. In Rainbird's research (2007), she explores to what extent training and education can help women who are predominately in low-paid local government jobs address in the issues women face in inequality. She assumes that based on the Human Capital theory whereby education, training and work experience are seen as contributing to qualities in the worker which are useful to the employer and rewarded in pay structures. She argues that those in low-paid jobs, predominately but not exclusively women have no opportunity for career progression, and that training for the immediate job is unlikely to give women opportunities for pay increase or career development. Rainbird also pointed out that even though many public sector workers take pride in the public service ethos and bring that to their job more than they are contracted to do so, it should not be used as a justification for their low pay.

March and Simon (1958) suggest that in industries and jobs where it is possible to predict work process, programmatic decision-making will reduce job autonomy while in those industries and jobs where it is not possible to predict work process, job autonomy will be increased. For example, it is argued that patrol police officers are the lowest ranking officers in the police organisational hierarchy, however they are the officers in the whole police force that have the most discretion at work due to mainly the solitary nature of the patrol function, with community police constables who are also able to

exercise a certain amount of autonomy over their work (Grimshaw and Jefferson, 1987; Fielding, 1995; Ramshaw, 2012;); “it is this ability to decide how to spend time which is the basis for the emergence of distinctive ‘styles’ of work” (Grimshaw and Jefferson, 1987, p.154).

These debates require special attention when applied to emergency service workers because public service professionals, “as holders of specialist expertise, expect to exercise a degree of autonomy over their work and their work processes” (Ferlie *et al*., 1996, p.168). In the case of emergency service workers the degree of autonomy is often confined to professional decisions in immediate situations and within a group-based decision making mechanism (Mather and Seifert, 2017). Autonomy is also circumscribed by the scrutiny of external observers.

It was only until after the recent “changes in philosophies and the structure of nursing, the educational pathways for nurses, the health care system, and society have led to generalised recognition of nursing as a profession” (Thompson, 2012, p.159). A large number of researches carried out on professional autonomy have mostly focused on general nursing practice, including the concept of job autonomy, and how it is perceived by nurses in different settings at various stages of their careers. The relationship between job autonomy and nurses’ job satisfaction, as well as the impact of dissatisfaction on nurse retention have been studied to help explore the reasoning behind the current global nursing shortage (Liu *et al.*, 2013; Meng *et al.*, 2015). The effect of job satisfaction on nursing turnover rates has also

been studied. Job satisfaction, a complex of organisational, individual, and environmental characteristics, has long been viewed as a critical factor in nurse retention (Thompson, 2012; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Blegen & Mueller, 1987; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006). Nurses' job autonomy at work has been described as an important element for nurses and autonomy of practice has been described as a key contributor to nurses' job satisfaction (Thompson, 2012; Aiken *et al.*, 2012).

It has long been discussed that investment in employee training and development has benefits for the organisation and for its workforce (Storey, 1995; Salas and Cannon-Bowers, 2001; Sloman, 2003; McDowall and Saunders, 2010). Nearly all organisations offer staff some form of training (Cannell, 2004). The Chartered Institute of Personnel and Development (CIPD) learning and development annual survey (2015) found most UK organisations describe the purpose of learning and development as improving individual and organisational performance through developing employee capability. On-the-job training is the most commonly used and considered most effective. Only a fifth of UK managers believe that formal courses are the most effective method.

Keep (1989, p.109-125) suggests that training activities "reflect the adoption of HRM within organisations". According to Storey (1995), HRM is a distinctive approach to employment management which seeks to achieve competitive advantage through the strategic deployment of a highly committed and capable workforce, using an integrated array of cultural, structural and personnel techniques. The main objective of HRM is to find out

ways to use labour efficiently and productively. Workers in this case are seen as a kind of valued resources for any companies, same goes to any resources, it needs to be properly used. Then the question of how it can be best used in order to bring out the maximum benefit for the companies becomes a question for HR managers. The notion of control exists through the management process, HRM is no exception. It is believed that training is placed ‘at the very centre of the business strategy’ due to it is seen as the main source of competitive advantage for companies. Therefore, training needs should be considered more focus on the organisational perspective rather than individually (McDowall and Saunders, 2010).

There are five main effective factors that influence training needs: organisational strategy, external labour market shortages, changes in internal labour market forces, changes in internal systems and values, and government initiatives and external support (Warr, 2002). Training is not necessary when the supply of generic skills or labour is plentiful in the external labour market because companies could choose whether or not to develop internal employees or recruit externally. However, once there is a shortage of current and future skills or labour, especially shortage of specialists, it becomes difficult to recruit externally and the cost thus consequently becomes more expensive (Ashton and Felstead, 2001; Sisson and Storey, 2000). Management training is necessary because managers are capable of reliable and efficient performance, high conformity, cost reduction, and ‘satisfying’ behaviour (‘social pleasers’) do not have enough capabilities to ensure a well-managed organisation (Storey, 1995). CIPD

(2015) found similar findings to previous years, 80% of organisations report they would carry out leadership development.

It is argued that training is seen as a fundamental element in companies' strategies, where training activities focus on building a high and multi-skilled instead of specific work-setting workforce, and increases the functional flexibility; training systems has a positive impact on quality and productivity which leads to corporate growth and prosperity (Cheung and Chan, 2012). Investors in People (IiP) was introduced in 1991 by the UK Government to help better the UK's poor industrial performance (Smith *et al.*, 2014). IiP was set up to help UK organisations improve the way they manage and develop their workforce. It is a quality standard by which organisations can measure themselves in relations to their human resource practices (IiP, 2015). One of the nebulous and unsatisfactory aspects of the training job is evaluating its effectiveness in order to optimise training quality (Pineda, 2010; Griffin, 2012).

However, the measurement of training value varies because the definition of 'value' varies from different angles and emphasis (Cervai and Polo, 2015). Training value measurement is fairly straightforward when the outputs are clear (Harrison, 2009). Some training programme might produce indirect values to business at the same time, and there are also some training programmes supposed to only focus on indirect values such as "cultural change" employee attitudes training programmes (Sisson and Storey, 2000, p.146) and the training courses such as customer care training and health

and safety training course which are implemented to enable people to develop the capacity to alter employee's attitude and social skills, then it is more difficult to measure the training added values.

Furthermore, it is also very difficult to measure the success of a management training course. Five aspects should be considered when measuring the values of a training programme: firstly, it is important to know why the values should be measured. That is to say, it is necessary to know whether training is to justify costs, to improve performance, to support career development or any number of other reasons. For instance, according to the IiP (2015), the investment in training can be measured by improved business performance when the training is tied directly to business objectives. Secondly, the measure target, which may be inputs, outcomes or reactions, should be determined. Thirdly, who takes the measurement process is quite significant due to there may be a range of stakeholders involved with the training process whoever participates in the evaluation will bring with them a personal perspective and hence a subjectivity to the evaluation. Fourthly, the timing and frequency of an evaluation is critical to the outcomes of the evaluation processes. In other words, the measurement period cannot be ignored because it influences the measurement result of training value. Finally, the measurement results may vary through different approaches such as financial report and feedback (Harrison, 2009).

However, every measurement method may have its advantages and disadvantages. Therefore, how to decide the measurement approach should

be considered more on the whole training and development strategy which generally fits within a wider HRM strategy (Felstead *et al.,* 2010). Explicitly, due to the unitarist nature of HRM perspective, there is no conflict among employers and employees on their goals and leadership and so on (Storey, 1995); therefore, the organisational competitive advantage through the workforce commitment should be placed at the centre of training strategy.

Training programmes facilitate organisations in increase employees' productivity and efficiency (Asadullah, 2015) to meet their goals of commitment, flexibility and quality (Carey, 2000). Ashton and Felstead (2001, p.166) suggest that "training has moved from being driven by business strategy to a position in which it is seen as the main source of competitive advantage for companies which is a goal of HRM."

As a component of employee development process, training is of key importance especially when it relates closely to organisational needs (Green *et al.*, 2016). First of all, skills training programme might influence organisational efficiency and productivity directly (Birdi, Patterson and Wood, 2007). For example, it may reduce the working error caused by insufficient skills or knowledge, increase the working speed, although it is difficult to provide sufficient evidence to correlate them. The higher efficiency and productivity consequently lead to the financial benefits profit to the organisation, which is the key centre of the organisational goals. Training programme may add values in analogous terms such as to increase in sales, conversion of leads to sales. nowadays, along with the keen market forces,

training also becomes an efficient alternative to reduce the expensive cost to recruit skills in short supply in the external labour market (Barrett and O'Connell, 2001), and an efficient alternative to shorten the recruitment timing with the rapid changes of labour market and technology (Sission and Storey, 2000).

Training programmes also produce indirect values to business (Zwick, 2006). For instance, customer care training may help organisations increase product additional value and enhance its brand or organisation image to retain existing customers and gain potential customers through better customer service by improving employee social skills and thus circuitously increase sales. This then leads to direct organisational profits. It is also believed that management training is another important aspect which adds indirect value to the organisation although it is hard to measure (Felstead *et al.*, 2010).

However, training is not supposed to be carried out to provide benefits to individuals as much as to organisation. One benefit to individuals is that when the organisation gains benefits from training activities, they will directly or indirectly become profits, then the employee whom involves in the training activities may share this profit through financial or other forms benefits. The value of training itself adds to individuals only exists when training provides employee transferable skills, which ensures employee could find another job in the labour market, but the transferable skills training programme

consequently causes high training cost to secure employee's commitment to the organisation (Altuntas and Baykal, 2010; Hsu *et al.*, 2015).

Training has become a must have feature in questionnaires studying labour issues around the world (Arulampalam, Booth and Bryan, 2004). Typically, such questionnaire would include questions asking respondents to indicate if they have taken part in job-related training in a specific period before interview, time spent being trained and whether they thought the training was helpful for their work. Based on these data, studies can examine the incidence of training activity and its potential link to skills and performance outcome (Birdi, Patterson and Wood, 2007). The study of nurses' attitudes towards training and personal development in this research supports Kanter's organisational empowerment theory that organisational factors within a workplace are important in shaping organisational behaviours and attitudes (Sun *et al.*, 2009). Nurses in China compared with nurses in the west, felt that they had less access to resource and training opportunities within an organisation (Laschinger, Wong and Greco, 2006).

2.4.1 Pay

Fox (1966) says employer-employee relationships have two distinct aspects: market relations and managerial relations. Market relations have to do with the terms and conditions on which labour is hired — they are therefore economic in character. Managerial relations arise out of what management seeks to do with its labour having hired it. They have to do with the exercise of authority and can for this reason be termed political in character. Pay and

performance are the main issues in the exchange between employers and employees, which reflects the connection between an individual's work and the performance of the employing organisation itself (Hegewisch, 1991; Metcalf, 2008; Brown, 2011).

Market relations determine the price of labour in terms of basic wage and hours of work, holidays and pension rights. Many argued in the industrial relations research on wages that they are undoubtedly, to a greater or lesser extent, market sensitive phenomena (Brown and Nolan, 1988; Brown, 2009; Bach and Kessler, 2012). The wages of labour are not akin to the prices of other commodities. It is an empirical question how far, in any particular society and circumstance, the market conditions of supply and demand dominate, or are dominated by, the influence of custom and of political processes in the determination of average relative wages (Nolan, 2012).

Gintis argues that "the neoclassical analysis of capitalism reduces to the examination of market relations among technological and psychological determinate actors" (1987, p.68). This theory demonstrates the free mobility in organisations, regardless of the influence of the labour market or trade union bargaining. It assumes that the labour market is a free and mobile homogeneous mass of labour with workers able to move from low-paid jobs to high-paid jobs. Thus, labour markets are perfectly competitive in this model, in which every person earns the same wage in equilibrium, differentials in wages arise when the demand and supply curve move up and down, when the quantity of labour supply in low-paid jobs goes down, this

shortage will rise and wages go up. When this supply moves towards the high-paid jobs, the surplus will force wages to decrease (Rubery, 1997; Crouch, 2011). According to human capital theory, in terms of job advantages, people have the choice of investing in themselves by securing appropriate education, training and work experience, which will benefit them (Baluch *et al*., 2013).

Taylor (1947) writes that in our system the primary criterion for wage determination is the mutual acceptance of employment terms by the parties of direct interest, such as employers and trade unions. State intervention threatens the existence of a free society (Williams and Adam-Smith, 2006). But it is very common to have the government's involvement in pay arrangements, especially when the government is "to regulate an economic process through tripartite or bilateral agreement to implement income changes" (Crouch, 1979, p.126). State intervention is usually done through direct intervention by enforcing legal regulations, such as, minimum wage, or through indirect intervention as with government practices of managing public sector pay systems. Through legislation and government policy, the state effectively is guiding and influencing workplace practices, including unfair dismissal, compulsory arbitration and unemployment benefits (Wood, 1978, p.78). State intervention in pay determination is usually at a macro-economic level, although the neo-liberal approach believes that no government should be involved in such process. State intervention influences the overall pay systems and the extent of unequal pay. For example in the UK, the state sets National Minimum Wage (NMW) to

improve material conditions for those at the base of the labour market, to reduce inequality, with minimal cost to the economy (Manning, 2011; Stewart, 2011).

Labour market structure is affected by government economic policies which shadows the composition of the pay structure. Although it is not always straightforward for government policies to change the labour market – the government as an institution in the labour market is not able to determine wage changes, but it uses its general economic policies to achieve what it hopes will be desirable wage polices (Robertson, 1961; Rubery and Edwards, 2003; Manning, 2011).

Fixing the appropriate level of pay and benefits is at the core of reward management systems. Various criteria may be used in fixing the pay of an individual, both within the organisation and in relation to the external labour market. While establishing relationships between different jobs and occupation which meet the needs of internal equity is a primary concern in the design of pay systems, linking these pay and grading structures to the external labour market and keeping pay levels competitive is also a vital concern (Metcalf, 2008). The level and composition of the payment package will be influenced by labour supply and demand either at national level or in response to the local labour market. In the external market, payment decision is based on an assessment of what rate needs to be paid to compete for staff in different types of labour markets (Brown, 2011). Besides, the non-competing groups, who are highly-skilled, hold special skills, have

special talents, may have advantages in the labour market competition, as they have more individual power to bargain for wages. They can choose to leave a job to get higher wages if the pay systems do not suit them (Grimshaw, 2007). Similarly, to the internal labour market, the level of pay for each level in an organisation's hierarchy would be set accordingly. It is argued that one group will earn higher incomes than another if its supply is relatively lower than the demand. These free labour market factors would limit the employers' discretion and influence management decisions (Millar and Gardner, 2004).

Different pay structures and pay systems may cause pay differentials established between groups of workers by occupation and the pattern of differentials on the basis of grade or status. These differentials mean the wage would vary from each person in terms of type of job, education, age, heterogeneity, experience, sex, race, and with the type of market in which labour sells its services (Kersley *et al.,* 2006). According to the Annual Survey of Hours and Earnings 2016 (ASHE), people doing different jobs may get paid differently, the occupation group with the highest median weekly earnings for full-time employees was managers, directors and senior officials, at £798. Caring, leisure and other service occupations were the lowest paid group, at £353 per week. It is also widely recognised women are often discriminated against in pay issues. The gender pay gap issue has been heavily featured by media lately and is much debated (Karamessini and Rubery, 2014). ASHE 2016 shows that in April 2016 the gender pay gap (for median earnings) for full-time employees is 9.4%. Although this is the lowest

since the survey began in 1997, the gender pay gap has changed relatively little in recent years. When part-time employees are included in the latest survey, the gap decreased from 19.3% in 2015 to 18.1%.

The minimum wage legislation is defined as the lowest wage rates that may be legally paid (Metcalf, 2002; 2008; Millar and Gardener, 2004; Stewart, 2011). The purpose of minimum wage is to reduce the extent and intensity of low pay, but not to eliminate it. The extent that the minimum wage helps with pay inequality depends on 'the decision-making process on the level each year, the employment opportunities and development of industrial relations' (Rubery and Edwards, 2003, p.466-7). Research on the NMW has shown that, since its introduction, it has served to reduce wage inequality both through directly raising the pay floor and generating knock-on effects higher up the pay structure (Manning, 2011).

The main reason of the trade union existence is to defend the position of their members, in particular by increasing their wages (Charlwood, 2004; Brown *et al*, 2009). Strong unions are able to "ensure their case of wage bargaining, is heard and taken into account by management, and can thus 'secure' a better pay deal for their members than market rates would allow otherwise" (Mathias, 1978, p.13). Pay bargaining process in reality is complex, trade unions' bargaining power also varies depending on the union structure changes. Freeman (1980, p.23) suggests that "union wage policies are designed to reduce dispersion of earnings within and across establishments, for what can be rationalised as plausible economic reasons";

and that union members “should not only be protected but treated equally” (Allen, 1971, p.49). The pluralist view of collective bargaining is that it is the best way to resolve employment conflict, because individual employees have very little bargaining power against their employers (Freeman *et al.,* 2005; Kersley *et al.*, 2006). This approach believes collective bargaining is essential to rule-making process (Flanders, 1975). Marxists view collective bargaining as a necessity (Wright, 2010). Hyman argues that the dominant feature of industrial relations is an “unceasing power struggle” (1975, p.26). But as Seifert (1992, p.6) points out, regardless of the perspective, the major concern of collective bargaining is always within “pay determination and productivity”.

The outcome and the impact of collective bargaining on pay varies, depending on the bargaining strategy, the relative bargaining power, the solidarity of unionised workers and the structure changes within unions (Brown and Nash, 2008; Brown *et al.*, 2009). The outcome of the wage-effort bargain can also be influenced by management attitudes towards workers (Hobbs and Njoya, 2005; Gold, 2009). However, it is believed industry bargaining for medical staff in the National Health Service (NHS) may have led to negative effects on service quality, which is measure by death rates, and productivity (Hall *et al.*, 2008). Such effects are caused due to industry bargaining which leads to low relative rates of pay for medical personnel in different areas with resilient labour markets.

The relative worth of each job or individual employee is subject to various influences, which include both market value and social value, placed upon particular skills and duties (Dickens, 2012). In making external market comparisons, the focus is on the need to recruit and retain staff, a rate being set which is broadly equivalent to the going rate for the job in question. Some employers consciously pay over the market rate in order to secure the services of the most talented employees. Others follow the market by paying below the going rate while using other mechanisms such as flexibility, job security or longer term incentives to ensure effective recruitment and retention (Purcell and Hall, 2012). In addition, workers themselves are able to force the hand of management. When workers are in a weaker labour market position, they normally turn to concentrate on finding a job and to worry about losing their current job. Once they have lost their job, finding another job becomes extremely difficult. This has given employers stronger right to manage. However, when workers are in a strong labour market position, they then have more freedom in choosing their jobs and will not be easily replaced because of their scarce ability. In this case, employees will have more power negotiating with employers and are harder to be motivated. Under full employment conditions, when labour is scarce, especially in terms of skilled workers or experts, the worker may be in a position to make a hard bargain with the employer. Thus, the starting pay levels and the pay systems must reflect the external labour market to a certain extent to avoid recruitment and retention problems (Grimshaw, 2007; Brown, 2011).

Discrimination is also a big problem when it comes to pay (Karamessini and Rubery, 2014). Gender bias can apply to either men or women (Rubery, 2014), but it is mainly against ethnic minorities and women (Healy *et al.*, 2012). Prejudice, segregation, unfair opportunities in selection, training, development and promotion can cause in equalities in pay (Williams *et al.*, 2011). The Equal Pay Act (2010), which has replaced previous legislation on equal pay, including the Equal Pay Act 1970, the Sex Discrimination Act 1975, and the equality provisions in the Pensions Act 1995, gives women and men equal treatment in the terms and conditions of their employment if they are employed to do the same work, their work are seen as equivalent under a job evaluation study, and their work are of equal value in terms of effort, skill or decision making (ACAS, 2010).

Job evaluation (ACAS, 2014) is a method of establishing the relative position of jobs in a job hierarchy, and attempts to measure the relative value of jobs. It does not evaluate people, it does not determine pay, but it provides a ranking based on the relative merit of different jobs. It compares different jobs within an organisation or an industry, or even nationwide, and ranks them in an order which may be used to determine relative rates of pay (Doverspike *et al*., 1983; Armstrong 2002; Nistor, 2012;). There are two types of job evaluation schemes: analytical scheme, where jobs are divided into individual components, every one of which is assessed and ranked separately, and non-analytical scheme assesses the job as a whole (Gilbert, 2005).

Whitleyism had given way to pay determination through PRBs (Pay Review Bodies) in some cases such as for nurses and teachers (Bach and Kessler, 2012), but it still has its influences in local government and health services (Bach and Winchester, 2003; Prowse and Prowse, 2007). Managerial relations determine the work that will be performed in a certain time, the specific task, the right to regulate the task and also the job, and penalties for failure to meet the obligations. The objectives of paying rates are sufficiently competitive to sustain the employment of the right numbers of appropriately qualified and experienced employees to staff and organisation; organising the pay package will facilitate control of operations and potentially save money; employers also seek to use the payment contract to motivate employees and thus improve their work performance; pay can be used specifically as one of the tools underpinning change management processes (Clegg, 1979; Hodder, 2015; Gill-McLure, 2018).

Pay is “the main issue in the exchange between employers and employees, which reflects the connection between an individual’s work and the performance of the employing organisation itself” (Hegewisch, 1991, p.28). Pay includes basic pay, holiday pay, overtime and all forms of bonus, merit or other supplementary payments. Being a reward, the supplementary payment is usually related to performance. Performance management activities provide the information needed to determine levels of reward in relation to contribution, and to plan salary increases in relation to progress and potential (Armstrong, 2002). Pay is used as a management tool to show authority and power. Management also uses pay to motivate workers to provide

responsive, high quality services (Heery, 2016b). Different pay schemes, such as bonus schemes are a way through which employees are rewarded, retained and motived (Marsden, 2007; Bach and Kessler, 2012).

One of the most important questions for organisations is to identify a way which allows incentives to work more effectively. An ongoing discussion concerns the choice between the carrot and the stick. Does one want to offer rewards for excellent performance or, instead, punish results that do not meet expectations? Standard economic theory predicts no difference between positively and negatively framed contracts that offer economically equivalent incentives (Essl and Jaussi, 2017). Most employers use bonus schemes to improve business performance (e.g. productivity, services, sales, profits) by providing incentives; to communicate and focus employees' efforts on key objectives; to motivate employees by establishing a clear link between pay and performance; to encourage change within the organisation; and to create the desired workplace culture by, for example, rewarding teamwork and good attendance. A reward strategy aims to align pay, benefits and other aspects of reward more closely with an organisation's objective. The most common aim is to help link pay to performance.

Another key objective of reward strategies was to improve recruitment and retention, aiming to attract and retain the best available people by offering a competitive remuneration package (Burgess *et al.*, 2004). Linking reward to business objective optimises the company's effectiveness. The objective of many organisations' reward strategy was to align their pay rates with market

rates. The definition of bonus payments is particularly broad. It encompasses sales commission, payments from certain profit-sharing schemes and earnings from piecework, productivity-based and other incentive schemes. Bonus schemes are usually introduced to provide incentives to make employees concentrate more on meeting particular business goals, such as improving productivity or sustaining high level of customer service. Bonus schemes can also help create the right working environment, and can help with recruitment and retention by offering employees shares of organisational success; bonuses also add flexibility to remuneration strategy by allowing staff to be rewarded as and when the business is performing well, without permanently increasing the pay bill (Bach and Kessler, 2012; Essl and Jaussi, 2017).

In recent years it has become common for companies to link bonus payments to performance against a wider range of factors. The total bonus payments in the UK in the financial year ending 2017 were £46.4 billion, the highest on record, an increase of 6.5% compared with the previous financial year, the previous highest bonus on record. Compared to the peak in bonuses in 2008 prior to the economic downturn, this is 11.3% higher than the peak in bonuses in the financial year ending 2008 (ONS, 2017).

Companies provide incentives for the completion of a project; workers can be divided into employee groups with different targets being set according to the function, department or business unit they belong to, have more direct influence and control over the targets they are working towards. At the same

time, individual performance can also be recognised and rewarded by bonus schemes. Payment by Results (PBR) and Performance-Related Pay (PRP) have been introduced in organisations as a main method of motivation. However, bonus schemes could cause resentment amongst workers. Sinclair and Seifert (1993, p.9) write that the performance-related pay introduced to state schools in England in the late 1980s intended to improve teachers' performances but because of the "financial constraint, deep mistrust of many aspects of the reform process and relative inexperience in handling industrial relations issues would make the measuring of performance and its forthcoming link with pay a damaging activity for schools". Also, where staff appraisals are linked to performance-related pay, it can create tensions for the appraiser-appraises relationship (Ironside and Seifert, 1995).

Aside from attempting to motivate and reward employees, management uses bonus schemes to help with retention of valued staff which helps stabilise an organisation's the internal labour market (Brown *et al.*, 2003). Both PBR and appraisal systems enforce local rather than national bargaining arrangements. After all, management uses bonus schemes to gain power and control over employees, as Seifert (1992, p.201) points out that the key to industrial relations is "to raise productivity and increase management controls at the point of production". Traditional analyses of bonuses have focused on performance measures such as output or profit, but companies now use bonuses for a variety of purposes, including employee recruitment and retention and to obtain better outcomes in quality and customer service (Nisar, 2006). These trends suggest that company decisions about bonus

payouts could be influenced by traditional concerns such as employee performance to the company's reputation among prospective employees and customers, and stakeholder influence. As a result, the growing importance of bonuses in total pay package has created interest in how bonuses can affect pay growth (IDS, 2003).

The latest CIPD annual reward survey reveals that 48% of the 715 organisations, across private, public and third sectors, operate performance-related reward; this is almost as many as those who say they do not (CIPD, 2017). Among the organisations that run a reward scheme, individual bonuses and merit pay rises are the most common individual performance-related reward scheme. The survey findings also suggest that performance-related reward has increasingly been used to facilitate good staff retention to address post-austerity contexts.

2.4.2 Performance-related pay

In any organisation the reward system is a central pillar of the employment relationship, and the best way to establish objective payment systems is to link and balance between job, person and performance (Kessler, 2005, p.317). Pay structure, which provides a framework to organisations to define the different levels of pay for jobs or groups of job (Armstrong and Murlis, 2007), is usually connected with the operation of systems of payment. Swabe defines PRP as "a system in which an individual's increase in salary is solely or mainly dependent on his/her appraisal or merit rating" (1989, p.17). It includes merit-based systems and goal-based systems. Within this

process, pay will be linked to performance, and employees would be fairly rewarded with respect to their achievements at work (French and Marsden, 2002; Marsden, 2004, 2007). The consequence of a successful PRP system will encourage employees to work harder towards achieving organisational goals and consequently improve the overall performance of the organisation. PRP schemes have become well-established in British workplace. PRP schemes give management greater control over the costs and performance of labour (French *et al*., 2001; Marsden and Belfield, 2005). The study of Pay Systems by ACAS (ACAS, 2015) reveals that employers can use PRP as a method of gaining increased control over the pay bill. Armstrong *et al.* (2011) argue that although studies have shown there is usually a positive link between reward practice and performance, studies have not been able to provide much guidance on which reward practices are likely to be effective in specific context.

The introduction of PRP is part of a move from collective to individual pay determination which makes management implement control over workers more effectively. With individual PRP schemes, agreements tend to set a framework for individual appraisal, Unions are thus unable to represent each individual worker in pay discussions. Many have argued that all the characteristics of PRP begin with cutting the power of trade unions in the traditional collective bargaining sense off at the knees (Kessler and Purcell, 1992; Seifert, 1992; Mooney and Law, 2007). Indications show it is difficult and costly for management to monitor its employees' performance accurately, besides, the effects on motivation and desired performance will

not be achieved when employees know that their better performance may not be rewarded because of a quota (Marsden, 2004).

Many argue that employees paid by PRP, especially where the incentive is substantial, tend to develop a narrow focus on their work (Gomez-Mejia and Balkin, 1992; Purcell, 2010). They concentrate on those aspects which they believe will initiate payments, while neglecting other parts of their jobs. PRP, because of its individual nature, tends to undermine team working. People focus on their own objectives at the expense of cooperation with colleagues. PRP, because it involves managers rating employees, can lead to a situation in which the majority of staff are demotivated when they receive their rating, and ultimately causes stress (Anonymous, 2017). This occurs where people perceive their own performance to be better than it is considered to be by their supervisors. The result is a negative effect on the motivation of staff that is unexceptional, but loyal and valued. These are often the very people on whom organisations depend most. Employees are rarely in a position wholly to determine the outcomes of their own performance. Factors outside their control play an important role, leading to a situation in which the achievement or non-achievement of objectives is partially a matter of chance.

2.4.3 Nurses' pay in the NHS

According to the study, Solving the Nursing shortage through Higher Wages, conducted by the Institute for Women's Policy Research (IWPR), increasing nurses' pay is the most direct way to solve the hospital nurse shortage (Lovell, 2006). Pay is the main source of income for workers, and plays a big

and important role for employers. Within any work place, one prominent issue for the employees and employers is the way in which labour costs are related to productivity (Gilbert, 2005; Wright, 2011). Management needs to use pay determination to minimise labour costs and to link pay to productivity (Buchan and Black, 2011; Woodward, 2012). NHS as the largest employer in the UK employs around one and half million workers, and in 2015/16, NHS received a budget of around £113.6 billion from the Department for Health (Press Release, Department of Health's settlement at the Spending Review 2015), of which £48.7 billion was spent on NHS provider staffing costs (UK health spending, IFS, 2017). In NHS England, staffing costs make up about three-quarters of the revenue expenditure in 2015/16. The total paybill for non-medical staff in 2015/16 was £35.7 billion, of which nursing and midwifery staff and health visitors are the largest non-medical paybill cost, with expenditure of £13.5 billion (NHS Pay Review Body, 2017). This has naturally drawn attention to the labour costs of nursing. In periods of reducing budgets and increasing demand the only way to try to maintain nursing standards is to alter the skill mix of those involved while cheapening the entire labour process.

Managers seek to deliver least-costly highest-productivity work using the concomitant payment systems and structures. These payment systems and structures are in the areas of management control at the point of production. In the UK, NHS Employers have national responsibility within England for negotiating on behalf of employers on issues such as NHS pay and conditions (Buchan *et al.*, 2014). Unequal and low pay are important

historical drivers for introducing and implementing new payment systems in the public sector generally (Rubery, 2014). Over half of all nurses in the UK are female; the nurse occupation is indeed a female occupation (Thornley, 2006). However the nurses' basic salary is much lower than the economy-wide median, and mostly gathered at the low end of the pay grades (Ackers, 1989; Thornley, 1998; Buchan and Black, 2011). Full-time registered female nurses earn less than the national average, and about £5,000 less than the national average for male nurses (ASHE 2017).

Nurses' pay is one of the most important areas of NHS and public sector pay policy (Thornley, 2006). It has long been argued that nursing labour shortages within the NHS are caused by problems of pay (Buchan, 1990; Bach, Kessler and Heron, 2012). One of main problems of nurses' pay is that it is predominantly determined by a national Pay Review Body (Bach, 1998; Thornley, 1998). Nationally determined rates are likely to produce uniform rates of pay, but these rates do not take local labour market conditions into consideration outside London. Consequently, wages for trained nurses within the NHS in certain geographical areas are less than the wages earned elsewhere within the same local labour market, either in other occupations within the NHS or within nursing. This causes labour retention issues (Spoor and Sutherland, 2007). On top of this, this same relative wage difference makes it hard for NHS managers to recruit qualified nursing staff. However, when pay determination power is passed to trusts or hospitals, it would allow local managers to exercise greater flexibility over pay. Many argued that when flexibility is allowed in pay determination, some contemporary labour

market issues would be eliminated (White, 1996; Buchan, 2000; Grimshaw, 2000;). This would help ease the nursing shortages problem especially in areas where there is a high labour demand, and that better wage offers from sectors and organisations outside the NHS more likely.

There are different processes by which pay may be determined and the processes of pay determination takes place at different levels within an economy. In any employer's wage strategy, both the choice of the pay determination process and the choice of the level at which this process occurs are important. Fundamentally, pay can be determined unilaterally by management. This can be done through management posting wage offers that any potential or existing employees are free to take up or reject (Manning, 2003). Management may also be prepared to negotiate on these offers, which inmates a process of individual wage bargaining between management and worker. Throughout the second half of the 20th century in the UK, the most widely adopted pay determination process was through collective bargaining, in which management negotiated collectively with employees, and most commonly employees were represented by trade unions.

Employers' pay determination responsibility may be removed when government-instigated third-parties are used to determine pay, for example, since 1983 Pay Review body system has been used to determine nurses' pay (Buchan et al., 2014). The process of pay determination may take place at different levels within the economy. In general, it could occur at the

workplace level, at enterprise level, and at the industry or sector level as a whole. The process is then described as decentralised when it takes place at either work place or enterprise level, and it is described as national or centralised when takes places at industry or sector level. What is more, many of the managers who attempted to do so only did it in a fragmented manner, which only targeted some occupational groups rather than others.

It is said that the nursing workforce in the UK historically was structured by qualification but are structured by grade now (Spoor and Sutherland, 2007). Those typically with two years training were known as state enrolled nurses, and registered general nurses typically had 3 years' training. Nurses are now differentiated by grade, this includes "junior staff nurses, at grades C–E; ward managers and charge nurses, at grades F and G; and senior nurses and nurse managers, at grades H and I" (ibid, p.117). Wage rates reflect the different grades. Women make up approximately 90% of the nursing workforce within the NHS. Generally speaking, women take up the lower grade level jobs, especially those working part-time (Lane, 1999, 2000a, b). According to Spoor and Sutherland (2007, p.127), most NHS hospital trust managers still make use of national pay review agreements even though pay for nurses could be negotiated locally. The main reasons behind those trust managers who seek powers to offer nurses a more competitive local pay is to make sure the existence of a wage premium for nurses working within the NHS. It is argued that this will help ease labour shortages because both labour recruitment and retention will improve. The NHS wants to increase the size of the nursing workforce through increasing the numbers entering

training and qualifying; recruiting foreign qualified staff; improving retention rates and encouraging those who work outside the NHS to return.

2.5.1 The division of labour and the changes of nursing role

It is argued that "in nursing debate has shifted from an almost exclusive focus on the boundaries between the work of nurses and doctors towards the potential for divisions within nursing" (Bach, Kessler and Heron, 2012, p.206). The increasing numbers of professional managers in hospitals not only add pressure on the workforce but also emphasised on the divisions between nurses and managers. There has been some acknowledgement that shifting occupational boundaries have consequences for lower paid healthcare workers, but most attention has been directed at the implications for nursing, compared to medicine, of following a more technically centred model of practice. This "stems from a preoccupation in nursing to shed its association with a gender defined image of 'caring work' skills that are invariably undervalued in the workplace and the academy" (*ibid*. p.205).

The UK experienced major changes in its health care systems in the late 1980s and early 1990s (Ham, 2014). It was during this time that the reforms instigated by the state had important implications for the shape of nursing work. The attempt was to redefine the relationship between public sector professionals and the government. The public sector medical profession was the primary target for changes and the government attempted to impose greater control over their practice and use of resources (Allen, 2001). The organisational reform brought two related issues – the relationship between

central government and local provision and the allocation of the funding and the accountability of actual spending needs (Ranade 1994, in, Allen 2001). The second was the tension between the doctors and central government as an historical deal done between the two meant that the doctors had the final power of how money was spent even though the state controlled the budget. These tensions were described as the NHS management 'problem' which became the basis of the subsequent NHS reforms.

The Griffiths Report (1983) called for major changes to NHS management including how the organisation was run and controlled were proposed. To ensure accountability to the state, a general management structure from top to bottom was determined (Dingwall *et al.*, 1988). The idea behind the introduction of general managers through this structure was in fact an instrument for bringing in managerial values which challenged those of the doctors. This had a hugely negative impact on nursing because nurses had already established a management structure, under the new structure they no longer had control over their budget and all power was placed under the new general managers (Strong and Robinson, 1990, p.5). Griffiths confronted how the NHS was managed and criticised that the services were directed to the benefits of providers instead of its users. Changes in this reform were mostly brought in by private sector managers who believed managers should proactively 'manage'. This new public management (NPM) intended to take away the culture of doctors' and nurses' self-regulation with in the NHS. During this period, there was a huge increase in the number of complaints about health service policy matched by local user dissatisfaction.

Again, being the front-line patient-facing professionals, nurses started to find themselves being in very difficult situations (Allen, 2001).

One feature of division of labour decisions in the public sector has been the use of cheaper, 'assistant' roles "including the expansion of community-support officers in the police service and a variety of assistant roles established in health and social care" (Bach *et al*., 2006, p.2). This highlights the ways in which new job boundaries and attendant task allocation decisions are intertwined with broader debates about 'eligibility rules', who may be employed, how many, training requirements, and 'performance rules', defining the tasks undertaken and the ways in which they are performed. More recent studies include new division of labour arrangements in the UK probation service (Gale, 2012) and in the English Further Education sector (Mather and Seifert, 2014). These studies find a tendency for service managers to reallocate tasks where possible to carefully set apart groups of workers with different job roles and on different levels of pay.

2.5.2 The labour market for nurses in the UK in relation to pay

The NHS recruits over one and half million workers and is one of the top five largest employers in the world. It has proven an attractive forum for experiments in radical restructuring (RCN, 2017). The UK nursing labour market review 2017 identified that the key UK labour market characteristics of the nursing workforce as these: firstly, around 87% of nurses and 80% of nursing auxiliaries are female; secondly, of qualified staff, about a third (31%) of nurses reported working part-time; among nursing auxiliaries and

assistants, 36% working part-time; thirdly, of those qualified, under 1/4 are aged less than thirty-four, and nearly half (49%) are aged forty-five or over. Fourthly, the number of those leaving the Nursing and Midwifery Council register is higher than the number joining, between 2016 and 2017, 27% more registrants left the register than joined, compared with opposite between 2015 and 2016, where there were more joiners than leavers; fifthly, geographical mobility of many qualified staff is restricted; and sixthly, the majority of both nurses (79.2%) and nursing auxiliaries/assistants (69.7%) labour force work for health authorities or NHS trusts/boards. Based on these figures, one in seven nurses and one in five nursing auxiliaries/assistants work in private or independent sector.

One of the main findings of the latest UK nursing labour market review shows that the crisis in the supply of nursing staff has arrived. Among the leavers, half cited retirement, while the others left because of working conditions, including staffing levels and workload, poor pay and benefits, change in personal circumstances such as childcare responsibilities, and disillusionment with the quality of care provided. It is also believed that the UK's decision to leave the European Union has led to the departure of EEA (European Economic Area) nurses, and this has further impacted on the shortage of the profession. Another potential cause for more leavers than joiners is the initiative to remove the bursary for nursing students in England, and to be replaced by student loans. Such initiative restricts the supply of nursing staff and may impact on the size and composition of the future nursing workforce (RCN, 2017).

In 2015/16, three-quarters of total expenditure for NHS England was spent on wages, in which £13.5 billion were given to nurses. The attention is once again drawn on labour cost. The two traditional mechanisms for controlling cost are, to use what is called a 'skill mix' method - to hire cheaper labour in exchange for more expensive workers' and to restrain the expectations in pay through dividing employee's representation, forcing funding cuts and changing pay determination structure (Bach et al, 2012). The UK nursing labour market review (RCN, 2017) shows, between 2010 and 2017 that qualified nursing staff have suffered in real terms a drop on 13.9% in pay.

In early 1990s, a new experiment to reorganise the structure for pay determination was introduced. It was suggested that the wages were determined at local level (Tailby, 2012). This decentralisation of pay determination was not welcomed by the health workers including the nurses (Coffey and Thornley, 2014). The nurses' Pay Review Body took on the role in getting this process started, they recommended awards 1995/6 and 1996/7 but left the 'top-ups' for local determination. As a result of this, nursing unions and associations have joined forces for the first time in rejecting the award. It was argued that in the UK 'nurses living in less affluent areas could be paid less than those in wealthier parts of the country' and that by having different local pay systems based on geographic variations 'are not only complex and costly, they can cause resentment between staff' (Irwin, 2011). Since then, *The Agenda for Change* national negotiations on a new pay and grading structure for each of the nursing and non-clinical staff occupational groups over 1999–2002 were signed off in membership ballots in 2004 and

the agreement was implemented by 2006. The 2004 pay settlement was seen as an improvement for low-paid workers (Marangozov, Williams and Buchan, 2016). With new nurse practitioners performing easy medical tasks; the numbers of healthcare assistants employed on the lower end nursing tasks grew. This has enlarged the occupational boundary span (Tailby, 2012).

As shown in the UK nursing labour market review 2017, the large majority nursing staff work for health authorities or NHS trusts/boards. This has given the NHS the power to influence nurses' labour market behaviour and nurses' pay. NHS pay levels set what the market rate for nurses' pay will be, instead of letting the market driving the levels of pay at NHS. Allowing different pay levels to be set locally rather than depending on one single national NHS pay rate may lead to confusion and complication but the NHS is likely to continue to exercise its unique power as the dominate, and sometimes the only employer in a specific labour market, when recruiting qualified nurses (Buchan *et al.*, 2017).

Low pay levels in nursing is the main reason for labour market problems and the key solution to labour market problems is through the increase of pay (Buchan, Seccombe and Charlesworth, 2016). This assumes that fixing pay levels will have a positive impact on both the nurses and on how the labour market behaves, thus a direct relationship between workers' pay and labour market behaviour. Aside from pay, there are other factors that affect labour market behaviour. Such as participation rates and turnover, but the evidence backing these arguments are often found to be insufficient and weak.

Although it has to be pointed out that nursing is not different from many of the other occupations in labour markets, in that there is no commonly recognised evidence of how pay impacts labour market behaviour.

The main pay system for most NHS staff does have some degree of flexibility built in, such as recruitment and retention, and a market forces factor, but due to a lack of capacity and resources, these practices have not been used much by local management. But in recent years, the centralised pay system has made a system-wide NHS pay freeze much more easily sustained than a decentralised or localised system could. The most recent NHS staff pay freeze was announced in the 2015 Budget and is planned to stay for four years, capping annual increases at 1% (Stone, 2015). This was slightly improved in 2018 with a 6% pay deal over three years. By which time, there will have been a 10-year period where NHS pay has been centrally restrained (Marangozov, Williams and Buchan, 2016). The relationship between nurses' pay and labour market is a complex one because it has to observe the effect of NHS being the dominate employer for nurses, the geographical mobility limits many nurses face, as well as the balance between nurses' career and family commitments (Buchan *et al.*, 2017).

2.5.3 Nursing process and changes in the nursing role

It is important to uncover the reasons behind changes in the nursing role and how that affects nursing process. The changes in the NHS show that over a period of twenty years the budget for nursing has been relatively reduced and as a result there has been a significant set of skill mix developments at

both the top and bottom of the scales. In turn this has created new problems associated with relative pay levels within the profession and when compared to outside equivalents, as well as calls for more and better training to allow all nurses to improve their skills and move up the pay ladder. The relevance for a study of hospital based nurses in any major economy is that as demand shifts with expectations rooted in attitudes to modern medicine, so supply comes under pressure and hospital managers, under government direction, seek a range of solutions which trade off pay and conditions with security and professionalism.

It is claimed that the concept of nursing process was first introduced in 1973 and it was not until 1977 that hospitals started to implement nursing process (Allen, 2001). Prior to the 1977 implementation, De la Cuesta (1983) believed that nurses in Britain practised its own satisfactory nursing process method: patient-centred care, patient assignment, total patient care, team nursing, and progressive patient care. Many (Melia, 1987; Allen, 2001; Proctor 2008) argued that the 'new nursing' ideology acknowledged the nursing role as being clinical rather than administrative. The traditional method of allocating nursing tasks was developed based on a hierarchical structure where a mixed of 'basic' and 'technical' nursing care were used in a hospital ward (Bach, Kessler and Heron, 2008). This method meant that a nurse performed the same allocated task on different patients repeatedly through a working day, and senior nurses had less direct contacts with patients. This new approach to nursing is intended to change such disintegrated care delivery system through seeing the patient as one person

of whom the nurse provided all care. Those who supported the ‘new nursing’ theory also encouraged the primary nursing idea where a patient’s caring responsibility was handed to a qualified trained nurse who worked with a team of other nurses as well as the patient and their family. ‘New nursing’ also changed the limitation of nurses only allowed to care for the biological functioning of the patient (Kessler *et al.*, 2010).

Braverman (1974) argued that capitalism used scientific management principles to deskill and cheapen the labour process. Employers set up a controlled work process in which managers designed the jobs and formed a monopoly of knowledge over the labour process. As a result, ‘workers surrendered their interest in the labour process, which had become “alienated”’ (Braverman, 1974, p.57). In the national agreement between Government, employers and school workforce unions set up to raise standards and tackle workload issues, assistant role was used to relive the skilled professionals from administrative tasks (DfES, 2003).

In recent years, organisational change has been a major factor of the impact on workforce structure in the British public services (Clark and Thompson, 2015). Bach, Kessler and Heron (2007) looked into how the change in the division of labour in the context of organisational change had led to the degradation and empowerment of assistant roles in education and health care sectors. Such roles in the public service include teaching assistants, healthcare assistants, social work assistants and community support workers in the police force. These assistant roles are routinely done by workers with

minimal qualification who are expected to work along more skilled professionals in a supportive capacity. Assistant roles are seen as a cheaper resource of filling in the gaps of recruitment and retention difficulties in the public service (Audit Commission, 2002). Bach *et al.* (2007) found that assistants in these posts were almost satisfied with their jobs and believed there were career opportunities for them to either develop in their existing roles or to move into a more skilled role. The lack of a consistent definition of the health care assistant (HCA) role has not stopped the role from either existing or developing (Kessler *et al.*, 2013). In 2012, there were between 106,500 to 270 000 HCAs in the UK providing supportive tasks to doctors and nurses (Health and Social Care Information Centre, 2012; Cavendish, 2013, p.6-15).

Thornley (1996) discussed the two features of the traditional model of nursing workforce development: less qualified nursing auxiliaries, later named HCAs used as substitutes for registered nurses; and the boundaries between registered nurses and HCAs have been unclear. The government supported the expansion of non-registered nursing workforce to relieve nursing shortage caused by poor working conditions. A common misconception is that HCAs and nursing assistants (NAs) are untrained and unskilled but in the research Thornley (2006) carried out to compare the roles of nursing auxiliary and HCAs, the findings suggested that although HCAs and NAs were more likely to under-report the level of their work roles because certain tasks were done unofficially and often unsupervised, both HCAs and NAs had begun receiving National Vocational Qualifications

(NVQs). NVQs in this case were used “to give recognition and accreditation for existing competencies/skills following occupational standards and norms” (Thornley, 2000, p.455).

More recent studies conducted by Bach *et al.* (2012) suggested the debate of the boundaries between nursing roles and doctors have shifted to a debate within nursing. Nurses seek to stress their unique contribution not only in relation to medical personnel but also comparing to other nurse specialties; they also seek to separate themselves from those in lower status roles among the nursing hierarchical structure (Allen, 2001). HCAs as a result have gradually taken the place of NAs and nursing auxiliary.

My research follows on from Goldthorpe’s study of workers attitudes towards their work (Goldthorpe, 1978) along with studies that look at labour process and employee relations in NHS hospitals. These include ones by Thornley on nurses' pay (1998 and 2006); labour process studies of nurse work (Grimshaw, 2000 and 2009); Carter and Stevenson’s study on the division of labour of teachers (2012), impact of new public management techniques on civil servants (Carter *et al.*, 2011), and those relating to management reforms and the management of nurse labour (Seifert 1992; Lloyd and Seifert, 1995, Mather and Seifert, 2014; Mather and Seifert, 2017). All these studies approach the topic using case study methods, and they also adopt an employee relations' stance with the emphasis on nurse attitudes towards their pay and conditions of service; their management; their colleagues; their

patients; and their tasks and task allocation. This is within a centralised state model with some hospital level management controls.

Overall these studies are situated within a wider debate about changes in public sector management from neo-liberalism (Chomsky, 1999) through public choice theory (Niskanan, 1975) to New Public Management (Hood 1991, 1995; Walsh, 1995). They include an analysis of the impact of changes in public sector management on specific occupational groups such as teachers (Ironside *et al.,* 1997); further education lecturers (Mather *et al.,* 2007); civil servants (Danford, 1999); local government manual workers (Gill and Seifert, 2008); and firefighters (Worrall, Mather and Seifert, 2010).

Based on Goldthorpe's model, where he studied car factory workers' and their work, and their relationship with workmates, this thesis is concerned to both describe the nature of the work nurses do in hospitals, and to provide an analysis of the nature of the relationships (with patients, co-workers, managers, and the profession) that define the job. There is a long-standing tension between nurses' desires to 'nurse' patients which includes both care and skilled treatment, and the demands of hierarchical management systems inside large organisation with constrained budgets. This is not a unique set of contradictions, but since nurses deal with the 'sick' in society their work is a touchstone for wider cultural sentiments regarding both the role of the state as keeping citizens from harm and the just rights of all humans within the orbit of the nation.

2.7 Conclusion

This chapter employed predominately UK literature to provide a detailed account of issues around the management of nurse labour. Through reviewing labour market influence, labour management theories, and discussing labour process, this chapter has highlighted the problems of nurse labour management and examined the solutions from job regulation, training and development, to nurses' pay and the division of nurse labour.

Human Resource Management uses the unitarist perspective and unilateral job regulation to maximise the utilisation of labour to seek to improve efficiency and productivity. Such an approach tends to support reduced workers' rights at work, as it believes in the total control over workers and expects no divided loyalty.

Scientific management (Taylorism), is largely based on this set of assertions and is deemed to promote the employers' interests through exercising 'management's right to manage' in order to improve productivity and efficiency. Scientific management sees worker as economic beings, with 'the one best way', workers are to do exactly what they are told; and this has become modern HRM which does not allow conflicts or disagreement, but it sees workers as resources that need to be correctly deployed, through control over rewards and performance.

This applies to all workers, even those with a degree of performance autonomy, and so, pay is a transaction in exchange for generally specified time, skills, commitment and loyalty. It is the central issue in distribution in

conflict between employers and employees. Pay systems and levels are therefore limited by the labour market, trade unions when relevant, collective bargaining if allowed, state policy, and the internal rules of the firm. PRP is introduced by management to help strengthen control over the costs and performance of labour. Although PRP links performance directly to pay, it still has some potential problems as performance, being ultimately subjective, is very difficult to be fairly and accurately measured, especially groups such as nurses. The disadvantage is of PRP system reflect the limitation of management control, and the complexity of labour processes at the point of production. Employers establish the pay systems, and the grading systems of jobs, in order to determine the level of wages inside the organisational job hierarchy. In the case of hospitals nurses, their performance is subject to management pressure, professional body regulation, and their own sense of the value they add to patients' well-being. Therefore, drawing on both labour process and IR traditions, through the prism of Goldthorpe's method, this study seeks to provide insides into the attitudes of nurses working in Chinese public sectors hospitals.

Chapter Three

Chinese context and case study hospital

3.1 Introduction

The purpose of this chapter is to set the scene of the case study. It will introduce a number of topics including the changing landscape of industrial relations in China, the Chinese pay determination process, Chinese health reform and Chinese health service personnel management, focussing on Chinese nurses at work and related labour issues. It will begin with a discussion on industrial relations in China, including its pay determination and its trade unions. This is followed by a discussion of Chinese HRM and its labour issues, with the aim to demonstrate that the economic and social system in China are increasingly similar to that of Western countries (Li et al., 2012; Wang, 2012; Frear, 2012), therefore Chinese workers can be analysed as any other worker, because the employment issues are the same. The Chinese health service and the recent health sector reforms in China will be explored, especially in relation to the ongoing changes that affect employment status and conditions for nurses working in Chinese public hospitals, especially the types of employment contracts for nurses.

It will then provide information on the Chinese health reform, including the changing role of the state in the management of hospitals and personnel. Chinese public sector hospital nurses as workers studied in this case study is written about next. This includes their work, their pay, their education, their characteristics, and the changing expectations of their work from the Chinese

government. In these discussions, the Chinese public sector pay system and the case study hospital pay system will be fully explained, as pay remains one of the most relevant known issues among Chinese nurses (Chan *et al.*, 2013; Zhang *et al.*, 2014; Shang *et al.*, 2014).

Finally, this chapter investigates the case study hospital. It begins with a general account of the case study hospital. Background information such as the history and the size of the hospital, the number of doctors and nurses it employs is introduced. This information provides a sense of the scale of the case study hospital, including its performance in relation to hospitals in China. Thus further sets the scene for the case study in the later chapters.

3.2 Chinese labour market

In 2016, China had a national labour force of 915.83 million people aged between 16 and 60 (National Bureau of Statistics of China, 2016a). The most recent generations of this vast labour force reflect the effects of China's one-child policy (Sheldon and Sanders, 2016). Since the reform of the employment system in 1986, private enterprises have been more enabled to recruit both skilled and unskilled workers. The traditional labour market in which the government assigned workers to employers would not meet the demand of this new development, so a more flexible labour market was needed to allow individual firms to recruit freely. The new system saw the Government's Labour Bureau introduce and recommend workers to enterprises instead of assigning them (Ying, 1995; Sheldon and Sanders, 2016). It was during this period that China first saw large scale rural labour

migration. The government development strategy permitted employers to disregard labour market factors outside their organisations beyond questions of supply and demand. This contributed to driving the rural population away from the countryside and to the industrialisation of the country (Zhu, Zhang and Shen, 2012).

Davin defined labour migrants in China as “all those who leave their areas of origin to live elsewhere, for whatever reason” (1999, p. 23). In the early days of labour migration, the government had concerns about its impact on social stability, and therefore issued and implemented policies to prevent unplanned labour migration from connecting rural and urban China. Between the 1980s and the 1990s, migrant workers who did not have a local *hukou* (household registration) or a *zanzhuzheng* (temporary resident permit) would be detained and subsequently sent back to where they came from (Solinger, 1995, p.129). Enterprises who recruited people without the relevant paper work could face a fine. This meant those migrant workers did not enjoy the protection or benefits of those with an urban *hukou*. They found themselves in the informal market which did not offer basic rights at work (Zhang, Nyland and Zhu, 2010). The laws and regulations protected those with proper work, *hukou* and a temporary resident permit, migrant workers who did not have such documents were exposed to exploitation.

This was changed in 2003 when the Chinese government decided to abandon the urban employment system and give every Chinese citizen the right to work in an urban labour market regardless of their residence

situation. The Central Committee of the Chinese Communist Party (CCP) and the State Council jointly stressed the importance and benefits that migrant workers contribute to economic growth. Since then, the government has made ongoing efforts in encouraging free labour movement (Wang, 2007). It is estimated that there are over 281 million rural migrant workers in China in 2016, making up nearly a third of the entire working force (National Bureau of Statistics of China, 2016b). Despite the changes, it has been found that workers from rural areas with a non-urban *hukou* face more pressure when gaining employment, such as difficulty securing employment, higher investment in job search and effort, lower starting wage, compared with their counterparts with a urban *hukou* (Wang and Moffatt, 2008; An and Bramble, 2017).

3.3 Industrial relations in China

Ding et al. (2002, p.431) stated that industrial relations in China "was a top down model" of a wider set of institutional arrangements. In the past decades, many have noted that western-style industrial relations have not yet evolved in China (Lansbury *et al.,* 1984; Warner, 1993, 1996; Taylor *et al*., 2003), but researchers have since looked into the increasing trend in China that human resource management are starting to adopt western HR practices (Child, 2009; Zhu, Warner, 2009, 2012; Warner and Zhao, 2011; Tang, 2012; Frear, 2012). Chinese industrial relations has been described as '*sui generis'* (Warner, 1996). The famous 'iron-rice bowl' (*tie fan wan*) employment system plays a crucial part in the development of Chinese industrial relations (Frear, 2012), and together with emerging and changing

employment systems over the decades, such reforms have produced a more complex deployment of human resources. The 'iron-rice bowl' employment system had its root in China since the early 1950s as Warner explains:

> "the system was originally intended to protect skilled workers after the Liberation in 1949, but eventually spread to cover the majority of urban workers. After leaving school, young Chinese workers were allocated jobs by local labour bureau, in most case with little reference to where they wanted to work and in which kinds of tasks. They were then assigned to work units (or *danwei*) which registered their citizenship status (or *Hukou*). In some respect, it exemplifies a 'Lifetime Employment System" (1996, p.200).

Under the 'Lifetime Employment System' (*tie fan wan*), workers had guaranteed, permanent employment, and are therefore committed to a single employer with little flexibility or mobility to change jobs. As a result, employee management was relatively simple and focused merely on personnel management (Cooke, 2005, 2009, 2011; Frear, 2012). One cause of the low mobility rate in the market was workers' citizenship status. It had a direct link between workers and their work unit, as the work units had to register workers' citizenships. Those who did not have a citizenship status were seen as 'non-persons'. Another feature of the 'Lifetime Employment System' was the practice of 'occupational inheritance' (or *dingti*), also described as "bequeath their jobs to their offspring" (Helburn and Shearer, 1984, p.4). The general principle of '*dingti*' was when a worker retired, they were able to nominate their children so they could pass on the job. This led to over-

staffing on an extensive scale. At the time, ‘occupational inheritance’ was a norm in work units. However, this feature has changed with the development of human resources management and government labour policy. It is now unusual for a retiring worker to nominate a replacement however it may still happen should a worker be found to have a terminal illness or die unexpectedly, in which case, it would be considered acceptable for their family to negotiate with the work unit.

Under this socialist ideology and political culture, the term and concept of ‘human resource management’ was not familiar to Chinese organizations. The government controlled staffing positions and enforced lifetime employment, which made performance management largely non-existent. As the state prohibited work units from dismissing workers, it was difficult for managers to manage low performance. Managers could not sack workers even if they were negligent, absent, indolent, or not needed (Child 1994; Frear, 2012). As a result, Chinese organisations found themselves in a pickle – overstaffing, low motivation, and declining organisational performance (Warner, 2012; Frear 2012).

When discussing recent economic developments in China, it is important to bear in mind the implications the changes that took place since the death of Mao Zedong in 1976 as well as the impact of the ‘open door’ policies brought in by Deng Xiaoping. Deng Xiaoping’s reform brought “greater efficiencies into the system by the use of market mechanisms” (Warner, 1996, p.196). One of the changes Deng introduced was price reforms, this enabled

enterprises to reflect their performance through profits. But with the reforms came price rises in many everyday items, including food. Wages were indexed so subsidies such as bonuses were introduced to reward efforts and encourage productivity. Many employers simply paid bonuses to everyone in order to keep harmony and avoid tension. Rewards such as bonuses were put in place to reward good performance though the way it was run was seen as inefficient. In 1987, a wave of wage reform took place initiated by the State Economic Commission. It was through this reform that SOEs were allowed to make decisions on their own reward levels as long as they followed the base wage plus bonus model (Cooke, 2009).

In the 1980s, Chinese workers' ability to move jobs was massively reduced by institutional and practical barriers (Helburn and Shearer, 1984). This was largely caused by the lack of jobs on offer, difficulty in securing work with a new employer especially when they had to conform to plans set out centrally by the government. Workers were not in a position to quit their jobs even if they wanted to. Warner (1996, p.199) wrote that at that time, China introduced what was known as a "three-in-one" policy, which used a combination of labour bureau, labour services companies and a group of networks to help with self-employment. Fixed-term contracts were also introduced during the 1980s and 1990s (Warner, 1986, p.113-26). Chinese public service employers commonly used what was described as a 'closed-shop' approach when it came to recruitment, selection and placement (Helburn and Shearer, 1984). In early 1983, the contract system was introduced as an experiment and was subsequently implemented within a

legal framework in 1986 (Chang, 1992, in Ying, 1995). At the time, contracts had to last for at least one year and must include terms covering “production task, prohibition, working conditions, remuneration, labour discipline and penalties” (Biddulph and Cooney, 1993, in Ying 1995).

While reforms in the 1980s mostly focused on restructuring the relationship between SOEs and the state, the 1990s saw important changes in the policy of labour management. Since the implementation of the economic reform and Deng Xiaoping’s ‘open door’ policies (Warner, 1996; Ying, 1995), China had seen significant changes in society including changes in its industrial relations system. SOEs had to lay off surplus employees; COEs as well as domestic private enterprises (DPEs) started to develop rapidly; and a large number of workers moved from the countryside to the cities. Employers did not particularly look out for the workers’ rights at the time (Ying,1995, p.1-37). China had no legislation on issues surrounding industrial relations and the first Labour Law was passed on 5 July 1994. This law was intended to “protect workers’ rights, adjust labour relations and set up an industrial relations system within the socialist market economy”.

With the Labour Law effective in 1995, it ended the socialist employment system and set out the legal foundation for market-oriented labour management (Taylor, Chang and Li, 2003; Cooke, 2009; Frear, 2012). This law required all workers to have a written labour contract with their employers, and it also granted employers the authority to terminate the labour contract if an employee failed to fulfil their responsibilities or when the

enterprise faced economic difficulties. As a result of this, the 'iron-rice bowl' system was taken away from the workers, lifetime employment and job security were no longer available. Following the introduction of the Labour Law, the central government continued to pass on management powers to employers, such as staffing and job assignment, but this has led to a big wave of SOEs laying off staff (Cooke, 2011; Frear, 2012). It is argued (Wang, 2007) that Chinese workers do not have a dominant power in restructuring the relationship between the state, the market and the individual workers. It is illegal to strike in China. The Chinese government treats unofficial labour dispute actions as crimes, but this has not stopped the Chinese workers seeking their rights and interests through a combination of legal and banned activities. This is how they search for their power in influencing the development of industrial relations in China: "One of the most important but least understood parts of the economic system of mainland China is that of the management of human resources" (Helburn and Shearer, 1984, p.3).

A set of new laws, including the Labour Contract Law, became effective in January 2008 (Brown, 2010). It provided a highly detailed regulatory framework covering issues of general provisions, establishment of labour contracts, implementation and amendment of labour contracts, and termination and ending of labour contracts. It also included special provisions detailing issues around collective contracts, labour hire and dispatch, and non-full-time labour contracts, monitoring inspections, legal liability, and supplementary provisions (Labour Contract Law 2007). Under the general provisions, the fundamental principles were laid down, such as the proposal

to improve the labour contract system, to protect the workers' legal rights and interests and to develop harmonious and stable employment relationships (Article 1, Labour Contract Law 2007). Many believe the Labour Contract Law is a distinct improvement on the existing legal framework regulating employment relations (Warner, 2009; Warner and Zhu, 2010), and it has enhanced the security of employment.

3.4 Pay determination in China

China did not traditionally have a pay determination system that is the same as we see in the West (Ding and Warner, 2001). The traditional Chinese payment system was based on the dominant form of industrial organisation known as the 'iron rice bowl' (or *tie fan wan*) policy (Ding, Goodall and Warner, 2000; Warner, 2011). This payment system was based on the principle of "from each according to their ability, to each according to their work (*gejinsuoneng, anlao fenpei*)" (Ding and Warner, 2001, p.321). Nearly all workers during this period worked for the government, the public sector, and were given "unified wage determination and absence of productivity-tied bonus system" (Lau and Leung, 1999, p.172).

The old 'low pay policy' managed by the government deliberately kept wage levels low so that the government could increase capital accumulation for investment in heavy industries. The only way for employees to receive a pay rise would be through nation-wide 'wage-increase campaigns' but this rarely happened. The centralised wage scale was described as a 'flat' pay structure in which workers' pay was kept low deliberately, and because of the way the

wages' system was managed and controlled, individual "enterprises were deprived of autonomy to determine wage levels of their employees in the light of business needs" (Ding and Warner, 2001, p.321-2). The central government set pay wage policies, wage structure and differentials, and so in reality, wages could not be used as a way to motivate or reward employees from different enterprises.

China went through the first phrase of pay system reform between 1978 and 1984. During this time, bonus pay was restored, but it was still centrally managed. Initially, the government decided that "maximum monthly piece-work pay was specified as 20% of the standard grade wage and the bonus could not exceed 12% of the standard wage" (Ding and Warner, 2001, p.322). The principle of the bonus pay was based on the collective performance of a work unit along with individual performances. SOEs began to have more autonomy over bonus distribution over this period. In 1979, SOEs were allowed to give bonus using their retained profits as long as the amount of bonus did not exceed two months' wages. This was later replaced by the 'bonus tax' scheme introduced in 1984 where an enterprise would pay tax on the amount spent on bonus pay that is larger than one-third of the annual wage bill. However, "increased bonus payments did not reflect the switch to profit retention and improved enterprise performance" (Walder, 1987, p.34). Enterprises were simply ignoring the rules the central government had set out and paid their workers more than allowed. This was even the case for factories that were making a loss.

As China continued to develop, a new round of pay system reform took place from 1985 and 1993. The dominant characteristic of this reform was that not only bonus pay but wages too were linked to enterprises performance. The government further relaxed the rules of bonus pay as well as wage determination. "The total wage bill of an enterprise was linked to a specified financial indicator, of which the most widely used were total profits, tax remittance, output value, and physical output" (Ding and Warner, 2001, p.323). Enterprises and factories were allowed to increase their total wage bill at a predetermined ratio as long as it paid the government a 'wage adjustment tax'. The central government decentralised its control over wage to local labour and industrial bureaus. Enterprises were encouraged to set up their own pay structure which they deemed appropriate for themselves. As the speed of development in cities picked up in the 1990s, the latest round of pay system reform started in 1993. The central government practiced a more relaxed approach to wage determination, devolving the power to individual enterprises as long as enterprises could keep the growth of their annual wage bill lower than that of labour productivity and enterprise profit. Local government was also called upon to help maintain sensible local wage levels. Along with these changes, the annual salary system was introduced for the first time that could be applied to senior managerial staff. The purpose of the annual salary system was believed to enable a large pay difference between workers and managers so that managers could be motivated to help improve the overall performance of the enterprise.

Some pay policies set out by the Chinese government were beneficial for the entire employment system, such as the minimum wage policy introduced in 1990s. This policy allows local government to calculate local minimum wage according to a predetermined formula, with reference to local living costs. Despite the government's efforts to allow minimum wage determination to take place locally, there has been an increasing pay gap between rural and urban workers. A study also found that factors like age and sex played a role in income levels (Lu and Song, 2006). Migrant workers were not covered by the social protection system, and education levels and types of enterprises also caused a pay gap between non-migrant workers and migrant workers. Pay differences between female and male workers have also increased (Yueh, 2004, p.163-164). Workers' involvement in pay determination has not been evident and the employers in China still retain the power of determining pay systems and structures.

3.5 Training and development in China

A key element of this thesis is concerned with is the working lives of Chinese hospital nurses in terms of their overall job and career satisfaction and their concerns for the future. The government is aware of this growing crisis of confidence among nurses and has introduced a raft of reforms associated with hospital management, pay systems, and professional qualifications (Xianyu and Lamber, 2004; The White Paper, 2017, China). These matters are now discussed through the lens of institutional change, while the findings chapters discuss these issues from the perspective of the nurses.

As more Chinese comprehensive hospitals continue to recruit and increase their number of nurses on fixed-term contracts, these nurse were found to be massively more dissatisfied with their pay, pension, health insurance and tuition benefits than their colleagues who held posts within the '*bianzhi*' system. Thus, these contract-based nurses have a much higher intention to leave their work than those with a permanent contract (Shang *et al.,* 2014).

Job satisfaction has long been the most consistent predictor of nurse intention to leave (Aiken *et al.,* 2002; Morrell, 2005). Relationships between nurse intention to leave and certain aspects of job satisfaction, including pay and benefits (Morrell 2005), career opportunities (Joshua-Amadi, 2002), have been identified. It has also been found that Chinese nurses with less than five years' work experience are less likely to remain employed than those who have worked for more than ten years (Liu *et al.*, 2012).

In recent years, as China opens up its doors to the West, many Chinese nurses seek to take up jobs in Western counties where they receive better pay and a more prosperous career development (Ho, 1995). As a direct result, China has suffered a shortage in nurses' supply especially those with baccalaureate degrees or above.

As discussed before, the Ministry of Health, China (MOH) stated that as part of the High-quality Care project, nurses' responsibilities include monitoring patient's condition, drug administration, assisting with daily living activities including toileting, eating, drinking, dressing and personal hygiene (MOH,

2010). These tasks have not only increased nurses' workload but have also taken away any time that the nurse could use to improve their professional capacity (Wang *et al.*, 2012; Hudspeth, 2013). Chinese nurses fully support lifelong learning and see the significance of intellectual growth, but clinical nurses are so busy with providing first-line care to patients that opportunities to take part in research or development programmes are insufficient (Pang *et al.*, 2009).

3.6 Chinese health service reform

By the end of 2012, the Chinese health service employed 9,115,705 people, including doctors, nurses, pharmacists, technicians, administrative and supportive staff. Patients received services from such professions 6.9 billion times in 2012 (NHFPC, 2012).

Since the 1980s, China has undergone various health reforms, together with the economic restructuring and transformation of social services (Ho, 1995; Sussmuth-Dyckerhoff and Wang, 2010; Shen and Jiang, 2010; Yip *et al.*, 2012). The Chinese government has introduced various market and managerial strategies to decentralise health planning and financing functions, hoping to introduce profit-making incentives and to promote diversified services (Wong and Chiu 1997). To help improve service performance and to reduce budget pressure for the government, two main strategies – decentralisation and the introduction of market forces have been adopted (Liu 2004). The purpose is to increase competition as well as to expand healthcare coverage, with basic medical care being provided by public

hospitals whilst special services offered by profit-driven enterprises. The state in this case subsidies “part of the personnel wages and some new facility investments” (Wong and Chiu 1997, p.81), while hospitals have been encouraged to increase their income and to improve efficiency. In my discussion with the head of the case study hospital, he explained that his hospital was only partly funded by the government and he emphasised that the funding his hospital received from the government was supposed to cover two main areas: special purpose funds and staff salary. But the actual amount of funding the hospital received year on year is not enough for either one of those purposes. He told me:

> “We receive a small amount of money from the government for staff salary. The money we receive from the government for staff salary only works out about 2-3% of what we need to pay them. The government also pays for the retired staff – but again, the amount of money we receive for this purpose only covers about 30% of what we actually pay those who are retired. So we still have to fund 70% of the retired staff salary and over 90% of the current staff salary”. The newly-completed building we were sitting in at the time of the interview was used as an example by the head of the hospital to illustrate how much the hospital has to pay out of its ‘own’ pocket. “If you want to build a new wing for the hospital, the government usually gives you some money. This building we are in now is not operating at its full capacity as we are still waiting for some equipment to be installed. The total cost of this building will be around 400,000,000 Yuan (£40 million), but the total funding I received from the government for this

building is 75,000,000 Yuan (£7.5 million), which is less than 20% of the total cost." He also said the amount of funding his hospital receives from the government is somewhere in the middle compared to all hospitals nationwide, "it's not very pleasing", he added. "Some big hospitals in Beijing receive a lot more funding – all it takes is for some senior officials in the central government to mention the name of a particular hospital and then that hospital gets the money. But again, this is very rare. There are limited numbers of hospitals who function like ours and there are also very limited hospitals that are fully funded by the government. Our government is not investing a lot of money in hospitals, so what if the hospitals need money? You have to make it!"

Table 3.1 Health expenditure in China

		1980	1990	2000	2012
Total Health Expenditure (100 million Yuan)		143.23	747.39	4,586.63	27,846.84
Percentage of Health Expenditure		100.0	100.0	100.0	100.0
Government Health Expenditure		36.2	25.1	15.5	30.0
Social Health Expenditure		43.6	39.2	25.5	35.6
Personal Health Expenditure		21.2	35.7	59.0	33.4

(Source: Chinese Health and Family Planning Statistics Yearbook 2013, NHFPC)

The total health expenditure in China had increased from 13.32 billion Yuan in 1980 (approx. £1.432 billion) to 3.785 trillion Yuan (approx. £278 billion) in 2012, the government health expenditure spending had risen to 30% of the

total spending after dropping to 15.5% in year 2000. But the total government spending was still 6% less than that of 1980. On the contrary, the percentage of personal health expenditure had increased to 33.4% from 21.2%. See Table 3.1.

As for the reform, the head of the hospital said:

> "When talking about the Chinese medical reform, we cannot simply borrow those methods which have been used in the west because they would not work in a country like China. China is very special and full of its own characteristics."

The consequence of the health reform is not straightforward, as there have been associated difficulties and problems in both rural and urban areas. In 1998, a significant reform in urban areas was to replace the traditional healthcare system with the new health insurance system called Basic Insurance Scheme for Urban Employees (BMISUE). This was to change the broader social welfare system (traditionally known as 'iron rice bowl' employment) (Grogan 1995). In rural areas, the new healthcare scheme known as Co-operative Medical System has been implemented since 2003. This scheme means the government and farmers will jointly finance the Co-operative medicine fund to avoid putting families into impossible situations for any medical treatment. Before 2007, BMISUE and Co-operative Medical System combined to cover a total number of 900 million Chinese people, but still leaving 420 million non-employed urban residents out of the state medical insurance system. In 2007, the State Council of the central

government introduced a new pilot - Urban Resident Basic Medical Insurance (URBMI) which to realise the target of establishing the basic medical security system covering all urban and rural inhabitants (State Council, 2007). The standard insurance cost of URBMI is higher than the new Co-operative Medical System but lower than BMISUE (State Council, 2007).

This pilot was initially introduced in seventy-nine Chinese cities, covering mainly middle school and primary school students (including vocational school students, secondary technical school students, polytechnic school students) children and any other non-employed urban residents. The scheme is voluntary (State Council, 2007).

To match the speed of economic growth and the increasing pressure of health service, health human resource development has been focusing on "to increase the quantity of the health personnel" (Gong *et al.* 1997:320). According to the Chinese Health and Family Planning Statistics Yearbook 2013, the numbers of doctors and nurses have increased tremendously. The number of doctors had increased from 1,153,234 in 1980 to 2,616,064 in 2012 and the number of nurses had increased from 465,798 in 1980 to 2,496,599 in 2012, a substantial increase of 535.98% (see Table *3.2*).

Generally speaking, the overall Chinese health service is under-funded by the government and the distribution of health resources is unbalanced among different regions. The government does not appear to have a

consistent investment strategy. As pointed out earlier, the total health expenditure as a percentage of GDP has increased but the government's spending as a share of the total health expenditure has decreased (Liu, 2004). The pressure of health service funding has led to dramatic institutional changes in Chinese hospitals, such as marketisation (Gu and Zhang, 2006; Zhang *et al.*, 2014). The head of the researched hospital emphasised to me that "the amount of money which comes from the government is far from enough, so are on our own, we have to bring in revenue; part of the revenue we bring in then pays for staff's salary and bonus".

Table 3.2 Health institutions and health personnel in China

Year	1950	1980	1990	2000	2012
Health institutions	8,915	180,553	208,734	324,771	315,000
Hospitals	2,803	9,902	14,377	16,318	19,900
Health Personnel	611,240	7,355,483	6,137,711	6,910,383	9,115,705
Doctors	380,800	1,153,234	1,763,086	2,075,843	2,616,064
Nurses	37,800	465,798	974,541	1,266,838	2,496,599

(Source: Chinese Health and Family Planning Statistics Yearbook 2013, NHFPC)

A number of nurses I spoke to told me both the hospital and the doctors had been relying on prescribing 'more than necessary' amount of medication for a long time - expensive medication to patients which could help generate more 'grey income' for doctors themselves as well as the hospital. The head nurse I spoke to also showed frustration that there was simply not enough funding to do what needed to be done in the hospital. It has been argued that "the governments' relative disinvestment has undermined the provision of health surveillance and prevention services" (Liu, 2004, p.535). The

“decision-making process in China moves slowly through a centralised bureaucracy’ and the government can only ‘cope with limited information at any one time” (Hillier and Shen, 1996, p.264), for those public hospitals that are massively under-funded, this means the only way to pay its employees is to seek possible alternatives.

3.7 The administration and the management of hospitals

Chinese hospitals are organised and managed as a part of the government administration system. It is argued that hospitals have had many inflexible characteristics as the political hierarchy is attached to the division of health authorities, and that the notion of bureaucracy and centralisation still influence the practices of the contemporary administration of public hospitals (Hillier and Shen, 1996, pp.259). Anand *et al.* (2008, pp.1775) explained that the administrative structure of Chinese health service includes three levels: firstly, the MOH in the central government; secondly, the provincial level, the administrative division in twenty-eight provinces which sits below the central government; thirdly county-level, health administration in counties or districts. The traditional socialist ideology sees the state belonging to all proletarians, so doctors and nurses are among those who are the rulers of the country. But in reality, doctors and nurses in hospitals are classified as staff, and are therefore subject to subordination to the Communist Party. For example, the principle of the latest health personnel reform, started in 2000, insists on “the Party being responsible for cadre’s affairs” (MOH, 2000, p.7). Those who work in the health service in China are counted as cadres. Hillier and Shen also argue that “the extent and force of party control is a matter of debate in

China but there's no doubt that its power remains paramount" (1995, p.259). The relationship between the government and health workers is treated within the context of cadre personnel management system, and this is one of the features of HRM with 'Chinese characteristics' (Warner, 2004, p.619).

Chinese public sector hospitals are the predominant deliverer of inpatient care to over 1.3 billion people. These hospitals account for approximately 80% of all of China's hospitals, and more than 90% of its inpatient hospital beds (National Health and Family Planning Commission of the People's Republic of China, 2012). The majority of hospitals are owned by the state and all health institutions are administered by health authorities centrally, provincially or locally (NHFPC, 2012), with the MOH having the highest authority that manages disease prevention and oversees all matters on national health. Health bureaus in each province, city and county, are responsible for regional policy development and service monitoring with different scopes and dimensions. Most public hospitals are managed by the city or county municipal government, with a small number of general hospitals managed directly by the provincial health bureau (Hu, Shen and Jiang, 2010). The case study hospital is under the direct management of the MOH.

China's hospital system is expectantly complicated as it services the biggest population in the world (Brown and Kuang, 1991; Zhang *et al.*, 2014). The system was established when China operated under a planned economy, which meant it has to accommodate both urban and rural areas. It also

resonates a traditional view on the re-distribution of social resources to the public according to the socialist ideology. Like many other Chinese public bodies, the distribution, financing and management of hospitals match its geopolitical and administrative divisions. The same goes with hospitals that are at provincial, municipal and county levels, they run parallel to governmental administrative hierarchies.

Health authorities in recent years no longer get involved in the day-to-day management of public hospitals as a result of management devolution. This leaves the management team in hospitals to manage personnel affairs and financial matters, all for the purpose of improving service quality and economic efficiency. Some (Pei *et al.*, 2000; Liu and mills, 2002; Liu, 2004;) argue that the effect of government's decentralisation policy has led to a lack of monitoring and controlling of public hospitals funding.

Liu claims this is because of "limited financial resources and few national administrative mandates" (2004, p.533). The MOH is not in a position to gain as much control over hospitals as it did when the country operated under a planned economy.

The Ministry of Finance, China (MOF) says in an official document that 'in principle the basic medical service should be subsidised by user charges' (MOF, 2000). But the central government has never made clear the proportion of the central of local government in funding hospitals which makes the health authorities' investment in public health organisations rather

vague. This was backed up by the head of the hospital: "… Our government is not investing a lot of money in hospitals, so what if the hospital needs money? You have to make it!" Chinese government's subsidy for hospitals declined significantly from 30% at the beginning of 1980s (Liu, 2006) to less than 8% by the end of 2007 (The World Bank, 2010).

Public hospitals do not have control in setting the prices for their services based on their actual costs (Li & Cao, 2008). The government usually sets the prices for medical care services which is below its actual cost in order to ensure every citizen can access basic health care services. However, the policy set by the government does allow service providers to receive a profit margin not to exceed 15% on drug sales (Karen, 2008). Such pricing policy forces hospitals to shift their services from less-profitable low-tech care to more profitable high-tech procedures and prescription drugs (Jin, 2005). Over-prescription of indicated drugs has been used as a corrupt practice by doctors (Fan, 2007; Tam, 2011) and had a big impact on nurses' everyday workload. Public hospitals are expected to take full responsibility for their profits and losses, despite the fact they have no control over the price setting for medical services and receive very limited government subsidies to fund their shortfall. It is found that the coverage for Chinese citizen's medical services is still quite limited even though around 92% of Chinese citizens have some form of health insurance (Yip *et al*., 2012). It is typical for patients to pay almost 50% of their total hospital costs out of their own pocket or through other individual funds (Sussmuth- Dyckerhoff & Wang, 2010).

Certain health authorities are reluctant to devolve their administrative control for fear of losing power. Control over key issues, such as personnel affairs and the allocation of public investment, is still commonly held by the government instead of the hospitals. This contradicts Liu's assumption that "decentralisation should be the reduction of the government's role in the health care" (2004, p.525). For example, the head of the case study hospital said: "Every staff's pay grade is set by the government... The government only sets the grades and the figures but does not give any money; the hospital has to make money in order to pay staff". As a result, charging patients fees has become a main solution to fund the running cost of Chinese hospitals, although no evidence is found that a purely for-profit service could cover the whole demand for health care (Liu and Mills, 2002, p.1695). But as Pei et al. pointed out, it is recognised that the effects of economic reform have affected hospitals in terms of "the dismantling of much of the organisational and funding base for health insurance" (2000, p.100).

Some believe that Chinese hospitals struggle with "the traditional dual mechanism" that are made up of administrative hierarchy and the party organisation, and these affect and limit mangers' ability to exercise autonomy (Pei *et al.*, 2000, pp.108). Usually, each hospital has a certain number of medical departments for its services, along with administrative services assisting hospital management. The hospital management structure "needs to correspond to that of the administrative bodies supervising it in dealing with different matters", and work is carried out by relevant bodies (Pei *et al.*, 2000, pp.109). But in Chinese public sector hospitals, too many

administrative departments are set up which has made hospitals less efficient and seemingly more bureaucratic (Jin, 2005).

In the Chinese contemporary political system, each hospital Party committee has absolute power to make decisions on the running of the hospital. A collective decision should be reached but in reality, the Party secretary and the head of hospital are key to decision making. It has been recognised that the potential tensions between hospital executives and Party officials create "a further constraint on the capacity of managers to fulfil their responsibilities" (Pei *et al.*, 2000, p.109). Heads of hospitals were given authority after 1985 when the Chinese government started decentralisation of health service management and issued a "hospital director responsibility scheme" which granted more power for these leaders to manage rewards, discipline as well as staff dismissal based on performance (Liu *et al.*, 2006, p.1837). This was to devolve responsibility to hospitals with the hope to improve services, but the health authorities kept certain powers including the level of funding, pay scales and the control of personnel establishments. For instance, the head of the case study hospital said he could not 'sack' a nurse because they are a relative of an old employee:

> "…what happens is, when the final annual performance result of each nurse is announced, an old hospital employee who has worked for the hospital for 30,40 years comes to me and says one of the nurses you are about to sack is my relative, my niece, my daughter, etc., please don't let her go. So what do I do now? Do I sack her? The answer is no, I can't let her go."

Putting aside the limitations from the upper administration, hospital managers have more autonomy on internal matters and their decisions are rarely challenged by subordinates. Liu *et al.* (2006) found in their study that the decentralisation of Chinese health management can give managers more control over staff management; whereas the central government focuses on the general policy of health personnel affairs and the appointment of key members. Another result of manager having more autonomy on internal matters is the concern over management power in controlling personnel through the use of more flexible payment and discipline methods. Management team in hospitals can use payment systems more freely to reach managerial targets, for example, increasing hospital income instead of improving staff pay.

3.8 Chinese health service personnel management

By the end of 2012, the Chinese health service employed over 9.1 million health workers (Table 3.2*)* including doctors, nurses, pharmacists and technicians, as well as administrative and supportive staff. The number of hospitals has more than doubled from 9,902 hospitals in the 1980 to 19,900 in 2012, as a result of the massive expanding of the Chinese health service. During the same period, the number of doctors has increased by over 100% from over 1.1 million to 3.6 million, and the number of nurses has increased by over 500% from only 465,789 to nearly 3.5 million. However, unlike other countries “China has more doctors than nurses” (Anand, 2008, p.1774). In 1980, there were over 3.4 times more doctors than nurses in China, despite

the 500% increase of nurses since 1980, there are still 200,000 more doctors than nurses in 2012 (Table 3.2*)*.

Since the founding of the People's Republic of China, hospitals in China were either state-owned or enterprise owned institutions. The relevant government authorities had been responsible for employment policy, planning and their implementation in these institutions until 1979. Such policies including wages, housing, and benefits were all determined centrally under what is known as the 'iron rice bowl' (Pei *et al.*, 2004; Zheng and Lamond 2009; Lamond and Zheng, 2010;). Under the iron rice bowl system, there was little labour mobility, job allocation was assigned by central agencies; staffing levels were not balanced with some areas overstaffed; and workers had very few incentives or rewards (Verma and Tan 1995; Leung, 2012; Wang, 2012). There was little management autonomy in recruitment and selection process as well as performance management, and staff dismissal of under-performance was virtually non-existent. It was believed that health care workers were promoted based on seniority and who they know, locally known as '*guanxi*' (connections) rather than merit (Warner, 1993 and 1996; Wang, 2012; Li *et al.*, 2012; Gong *et al.*, 2013; Chen *et al.*, 2013; Wang and Seifert, 2017).

Recent labour market reforms in China have seen the decentralisation of the management of the labour force, a move from an administrative focus to a managerial one, and an emphasis on increasing productivity (Zhu and Dowling 2001; Sheldon and Sanders, 2016). It is argued that the

decentralisation in the SOEs and the development of joint ventures with western companies have given organisations increasing freedom to control their human and financial resources and on the surface many managers appear to be adopting western models of human resource management (Warner, 2011).

HRM can be seen as the use of a proactive, integrative series of interventions, which helps promote the integration of organisational strategy, cultural change and dialogue between key stakeholders at the workplace (Zhao and Du, 2012). The concept of HRM was largely brought to China through management practices used in foreign owned companies and the growth of joint management training courses between Chinese and foreign universities (Braun and Warner, 2001). Over the years, China's public sector personnel management was centrally controlled by the state. The mobility of human resources in China was also once tightly controlled by the Party and its iron rice bowl system (Cooke, 2011; Frear, 2012). The Chinese Health service, like many other public organisations in China where "seniority was the key promotion criterion and poor performances were tolerated" (Cooke, 2005, p.42). The head of the case study hospital said:

> "Everyone's work is evaluated. But our performance evaluation scheme is not more than just a process. What we really evaluate is how much you contribute. How much do you contribute has a direct impact on how much you earn. Chinese people are used to the 'big bowl of rice' system (Daguofan) – yes, everyone talks about evaluation, but evaluation in China is simply to just go through the

formality, no real meaning. No one really gets praised or punished as a result of the evaluation process."

Since the economic reform took place, the Chinese government has gradually let go of its tight control over the running of health institutions, including "delegation of health service to increase autonomy of health service" and moving management power from central government to local authorities (Liu *et al.,* 2006, p.1837). As a result, hospital directors have been given more power in decision making on matters include, recruitment, reward and performance. Medical education and training have also been highlighted by the government to increase health personnel quality. This was especially the case since the 1990s, when it was called "for a major reassessment of the skills and knowledge that health workers require in order to deliver a package of essential services" (Gong *et al.*, 1997, p.327). Despite the government's plan to decentralise control, the reforms met difficulties. First, hospitals still need to follow government's arrangement for staffing and funding. This reflected an incomplete policy adjustment in other areas of employment and welfare policy (Hu, Shen and Jiang, 2010). Although it has become possible for hospitals to manage its internal staffing, reward and training, however, the number of new doctors and nurses a hospital can recruit is still subject to local authority's quotas. Second, the Party's influence remains in all public service organisations at all levels, medical institutions included. Gu (2011) pointed out that Chinese hospitals are actually managed by officials, not by professional managers, and as such are the legacies of the old system. The Party's influence is also reflected by the way senior

hospital managers are appointed. Each senior hospital manager has to be nominated and appointed by Party committees, because Party committee at every work unit retain a dominant position in overseeing personnel management and other key issues.

There is also a big gap between the distribution of health personnel in rural and urban areas. With more resources allocated to urban areas, many better-qualified practitioners have left for more attractive positions in county or better-wage regions (Hu, Shen and Jiang, 2010). Since the government emphasis on improving the quality of health personnel, professional education and training are key to the strategy. Medical education was first introduced by foreign missionary institutions in the late 19th century, and was gradually development through the first half of the 20th century. By 1949, medical education was still limited, only 15,000 medical students were enrolled compared to 541.7 million population at the time (Gong, Wikes and Bloom, 1997). This situation saw major improvement after the 1950s following the Soviet model with a more inclusive medical education system was set up to allow more students to study medicine. China has 96 university medical schools and 447 secondary and specialised medicine colleges providing different levels of education in medicine (MOH, 2004, p.275). These institutions helped the number of medical students to reach 1,002,828 in 2011 (NHFPC, 2012).

However, the demand and supply of both Chinese doctors and nurses are influenced by the development of the health labour market. The demand for

health practitioners in China will continue to rise in the years to come, as a result of population changes, health demand increase, medical technology advances, and economic and educational developments (Chan *et al.*, 2013). However, it is not clear the supply of medical graduates is connected with demand, because in recent years, higher education bodies including colleges and universities are trying to increase the number of students enrolled year on year. Moreover, the fast development of university medical education since the 1990s has created difficulties for medical students to find employment in the health service. The surplus of the trained health workers indicates "a less than optimal allocation of educational investment" in the Chinese health education system (Anand *et al.*, 2008, p.1779). As an example, in 2006, 279,700 medical students graduated from Chinese universities, but the number of health personnel only increased 164, 000 that year (MOH, 2008a, China Health Statistics Yearbook 2008). This poses a serious challenge for the Chinese government to ensure that medical education quality is maintained during university expansion.

Health workers including nurses, doctors and technicians need to hold relevant qualifications from colleges or universities. For example, the head nurse of the case study hospital said those applying for a job as a nurse in the hospital needs to meet the 'qualification requirement': "...The minimum qualification needed to apply for a job at our hospital is a college degree from a recognised establishment." Although the head of the case study hospital does not think it is necessary to have nurses with university degrees:

> "Where do we recruit nurses? Mostly applications are new graduates. The minimum qualification they must have obtained is a college degree. We have also recruited nurses with undergraduate university degree and sometimes master's degree. But why do we recruit college degree graduates? We don't think it's necessary for nurses to have university degrees. In the past, to become a nurse, you only needed to have a secondary technical school qualification, but now there's a trend of increasing the nurses' qualification, which again means an increase in staffing cost. The actual tasks nurses carry out do not require a university degree. These days, we recruit about 20 nurses with university degrees and another 100-200 nurses with college degrees annually, we very rarely get applicants with master's degree."

It is reported that there are fifty-eight postgraduate nursing programmes in 2007 (Li & Shang, 2009), and 10 PhD nursing programmes in 2008 (Ma & Liu, 2009). Students who passed the National Entrance Examination for postgraduate studies can choose from a list of nursing related master degree courses, including nursing management, nursing education, clinical nursing, speciality nursing, medical-surgical nursing, community nursing and psychological nursing (Liu, *et al.*, 2009). But China does not have enough nursing academics to supervise these postgraduate students, so doctors or academics from other disciplines step in to help which meant the topics of research and the direction of studies have not directly benefited the nursing profession (Wong, 2008, 2012).

Table 3.3 Levels of Medical Training Institutions and Qualifications

Training Institute	Level	Duration	Qualification	Admission
Medical university or college	National, province and municipality	At least 4 years	Qualified doctors/nurses/technical specialist	Senior high school graduation, National higher education examination
Post-secondary medical college	Province, city and prefecture	3 years	Qualified doctor/nurse/technician	Senior high school graduation, National higher education examination
Secondary medical school	Prefecture or city	2-3 years	Assistant doctor/nurse/technician	Junior high school graduation
County health school	County	<2 years	Village doctor/nurse/technician	Senior or junior high school graduation

(Source: Cao, 2014)

In China, graduates from medical universities mostly end up working in big health institutions as they provide better conditions. Table 3.3 shows the categories of training institutions and qualifications relating to different requirements for health workers recruitment. Those attending secondary/vocational medical schools would be skilled to become middle level health workers such as, assistant doctors and nurses. Village doctors, nurses' assistants, midwives and assistant technicians would normally receive training through ongoing education, in-job training and pre-service training (Gao et al., 2017).

3.9 Chinese public sector pay

Chinese public sector employees take a very large proportion among the four groups of employees living under the state fiscal income. For example, by the end of 2016, over 61.69 million workers were employed in the public sector with a total wage bill of over 4.44 trillion Yuan (approximately £446 billion) (National Bureau of Statistics of China, 2016c). '"Public sector' in China refers to those public sector organisations providing public goods and services to citizens, which are not for profit making, are maintained by state fiscal expenditure and under the control of governmental organisations" (Cheng, 2000, cited by Cooke, 2005, p.3). Public sector organisations in China therefore mainly include science, education, culture, health and sports institutions. The head of the case study hospital confirmed this by saying: "A public hospital like ours is expected to serve the public and has to show the hospital's interest is the welfare of the public."

According to Cooke (2012) the public sector pay system in China has experienced three major reforms during the last five decades, which were simply adjustments to the social development of the time. Currently wage levels are centrally and unilaterally determined by the state, and managers are only involved in administrative function and policy implementation. There is hardly any wage bargaining activities for public sector employees in China.

"It has long been recognised by social scientists that wages perform a number of different functions within an economy, such as price allocations, social stratification and social cohesion and the management tool functions"

(Rubery, 1997, cited by Cooke, 2004, p.12). Pay in enterprises in China is mainly considered to be a very important tool to attract and motivate employees so as to improve performance. At the same time, the effectiveness of using pay as an incentive has remained debatable, however, in the public sector in China, pay is seen as "a necessity to cover the living costs of the employees themselves and their family" (Cooke, 2004, p.12). Before the economic reform, most health workers working in public sector hospitals and health organisations had a guaranteed life-long job and their pay followed a national wage payment system which had very narrow differentials between scales. Hospital managers did not have incentives as their salaries followed the same method as health workers (Bloom, Han and Li, 2001). At the case study hospital, the pay differentials between senior management and staff are not distinguished by pay, as noted, all public hospitals are expected to follow the pay structure the government has set out, each hospital has very little flexibility in terms of varying employees' basic wage. The head of the researched hospital said:

> "So as a head of the hospital, I believe my contribution is worth 500,000 yuan (50,000 pounds) but in reality I'll never get that amount. I receive 10,000 – 20,000 yuan (1,000 – 2,000 pounds) a year. Technically speaking, the gap between my pay and an unskilled manual worker's pay should be quite big, but currently there is no structure or policy in place to honour it. Especially in a public, state owned hospital like ours, we must follow the government's pay structure and rules 100%."

The basic wage is the main part of the earning structures for public sector employees in China, together with holiday pay, various position allowances and bonus pay. Public sector pay reform in 2006 has classified different roles into various levels in order to distribute wage to a specific role. This wage structure is made up of four parts: post wage, level wage, performance-related pay, and subsidies appropriate to particular jobs. Post wage and level wage are the basic pay, and it reflects the policy of “one post, one wage”, which means once the post changes, the wage changes accordingly (Ministry of Personnel, China).

However, the long-standing iron-rice bowl system meant pay differentials between health workers were very small, and the pay differentials did not reflect real contributions or the level of expertise between different professions. The government has been raising public sector pay levels since the 1980s, aiming at overturning the egalitarianism tradition and making a move towards greater differentiation in earnings based on performance (Child, 2009). According to the head of the case study hospital, pay levels seem to have been reverted back to a time where people shared ‘equal pay’:

> “In our hospital, doctors and nurses earn similar amount of legal pay. I don’t think this is right but you cannot change it. In a public institution like ours, if you wish to enlarge the pay gap between doctors and nurses, you will meet lots of resistance because everyone believes ‘the mean idea’. This structure does not allow you to enlarge the pay gap, especially not at the moment; the government is calling for a ‘harmonious society’. One of the things I feel that is happening to form

a ‘harmonious society’ is a reversion of pay levels, how much do you revert? Of course this is not 100% expected, but towards the direction of reverting pay to a level where people share equal pay. This means how much you earn is not dependent on how much you contribute.”

At the moment in China health workers’ pay is usually made up of two parts: the fixed basic pay and the flexible bonus and allowance pay (Cao, 2014, 2015). The fixed basic pay is determined by a national pay scale, while the flexible bonus and allowance part is usually defined by the hospital or the health institution themselves. Generally speaking, the fixed basic pay does not link to performance while the flexible part is changeable dependent on the amount of hospital revenue, each clinical unit’s profit and individual workers’ economic contributions. So health workers’ final salary is highly dependent on the level of hospital revenue. Having said that, in China, the commonly-known informal payment ‘*Hongbao* (red packets)’ is another income source for health workers, and it is offered by patients in exchange for special services (Bloom, 2001; Yang, 2013; Cao, 2015).

It has been widely accepted that this income given to, usually surgical doctors and nurses, is an extra-legal income for them because this source of income is not monitored by anyone. Patients and their families believe if *Hongbao* was offered and accepted, then it would indicate not only better care would be provided but also a sign from the doctors that they are confident the surgeries would be a success (Cao, 2014, 2015). Patients feel obliged to thank the medical staff by giving them an informal payment or gif

for the care and service they receive (Chiu *et al.*, 2007; Yang, 2013). It is not possible to estimate how much each patient puts in their *Hongbao* or the amount a doctor might receive in total every month but as the head of the case study hospital pointed out numerous times during the interview that doctors do not rely on either their basic pay or hospital bonus. The government, as well as hospitals have over the years tried to stop this phenomenon from happening, however, it still widely exists, and more importantly, patients want to feel more assured only if their *Hongbao* is accepted. Despite some thinking that this phenomenon is 'both illegal and formally unprofessional', it does not seem to have caused adverse clinical outcomes (Fan, 2007; Cao, 2015).

The government's previous statistics showed health workers' income is higher than the average level of income in the public sector. Although professions in other public sector bodies, including higher education, the financial and post-telecom services receive more than those in health services. But it is important to point out here that the official figures published by the government only include the fixed basic pay and the flexible bonus pay, while informal sources of pay, such as undisclosed *Hongbao*, are not included in these figures.

However, this system has resulted in low basic pay and excessive use of bonus systems, which forces hospitals, hospital managers and staff to focus on profit making (Cao, 2015). The widely-accepted *Hongbao* phenomenon has also cast a shadow over the transparency of doctors and nurses' income

(Chiu, 2007; Yang, 2013). As a result, an important element for personnel reform is to transform the pay system and to acknowledge the value of practitioners by using a new flexible and incentive pay system (MOH, 2005: Chapter 4, Section 17). A policy document - 'The implementation advice on deepening health services personnel system reform', is the reform guidelines issued in 2000 by the central government. The major goal for the government is to establish a new personnel system with an effective payment system that can motivate health workers.

As a result of this, three types of public health service units are established using different payment methods: 'Fully-state-funded units' would distribute wages based on the government payment system; 'semi-funded units' would receive pay calculated based on internal policy, but the overall pay would be limited within the government quota; 'self-funded units' could set up their own payment system, but the level of pay rise could not exceed the increase in economic output (MOH, 2005: Chapter 4, Section 18).This in effect means workers' pay determination process very much depends on the category of the health service units - with fully-stated funded units following the government's payment system; semi-funded units drawing up their own payment system within the government's guidelines; and self-funded units determining its own pay system. Since most public hospitals are categorised as semi-funded units, these hospitals now have the freedom to set up its own internal payment system, knowing the actual investment from the government would not increase. This further indicates that the central

government encourages hospitals to generate income so that they can pay staff using this income. The head of the case study hospital explained to me:

> "..some hospitals who separate revenue and cost, like our hospital – what that means is all your revenue goes to the government, then the government gives back all your cost. This is another reform model the government is trying to experimenting."
>
> "The most difficult thing in the health reform is the government investment. It varies depending how well-off the local government is…not all local government can afford to fund its hospitals fully. In (our) ShaanXi province, only about 20% of the local government can afford to fund its hospitals. Central government budget does cover this cost, it all has to come from local governments. Because doctors get bonuses so nurses get treated the same. Bonus pay money comes from the hospital's income."

Another method used in personnel reform is to stop "the permanent employment mechanism" and "increase dynamic support to medical talents" (MOH, 2002a: Chapter 3.2). The introduction of this contractual employment reform intends to increase individual performance and efficiency. The government's aim is to develop human resources management and improve health organisation's total performance (Liu *et al.*, 2006). But it is hard to implement such reform because changing employment status could threaten job security and consequently cause resentment from the workers. Hospital managers prefer less radical policies so that they stay in control over employment issues, but at the same time, using bonuses as a solution to

expand pay gaps between professional grades and to improve performance have indicated positive results, though the long-standing egalitarian culture remains prominent (Liu, 2004).

3.10 Changes in public sector hospital wage setting

Collective bargaining in the public sector varies across international boundaries as each country runs its own systems according to its regulatory processes through which terms and conditions are determined. Such processes include “free collective bargaining, independent pay review, unilateral employer regulation and fixed-rule employer regulation” (Grimshaw *et al.,* 2007, p.593). However, free collective bargaining for the entire public sector workers only exists in a few countries such as Germany and the Netherlands. Pay review bodies in the UK typically apply to professional employees and make recommendations to the government based upon evidence from employer and staff-side representatives, as well as government. In the UK, separate review bodies apply to the armed forces, prison workers, police, doctors and dentists, teachers, and nurses. Lastly, the state may apply an established fixed rule, especially negotiated or imposed as a way of providing compensation for those employees who do not have the right to strike.

Another difference between countries is the degree to which there are arrangements that enable centralised wage-setting to be shared and complimented with regional or organisational level set up. The UK has provided a large number of cases of decentralisation that began in the late

1980s, when the introduction of internal markets for professionals in education, health and the civil service sectors. The most significant reform has been among the civil servants, a separate system was established for individual departments and newly founded agencies, which replaced the national framework (Bach and Winchester, 2003); in education, health and local government, within centralised national agreements, local flexibility including recruitment and retention are provided with the national agreement for public sector hospitals (Grimshaw, 2000).

The integration of public hospitals' wage setting in the wider public framework inevitably becomes more complicated when the public sector itself is subject to government policies of rationalisation, spending cuts, and the beginning of marketization (Grimshaw *et al.,* 2007). What is more, the conflicting interests of public and private hospitals potentially undermine coordination. Lastly, the role of coordination institutions and agencies faces changes due to the transformation of collective wage agreements which facilitate tailor-made employment conditions at the local level.

Buchan *et al.* (2014) pointed out that the outcome of wage setting can be an incentive or disincentive for recruitment and retention in the health professions and for motivation to work in certain regions, specialties, working locations, and working times. Pay is found not to be the only incentive; working conditions, career development, education opportunities, flexible working arrangements and participation in decision making have also been identified in their research as major motivators for health professionals as

well as sources of job satisfaction. Their research also presented arguments of the effects of monopsony (Manning, 2003), it argues that an absence of monopsony in labour markets for nursing, especially where there is only one major employer in a labour market, means that nurses wages in these labour markets are lower than where if there were more employers needing and competing for nurses' skills in free market.

In the health sector particularly, attempts at system reform have at times included experiments to shift the arrangement of pay determination from national to local level based on the principle of giving greater managerial flexibility and decentralising power. Localised wage arrangement means that local management teams can influence and have more managerial input into controlling wage levels, along with gaining more authority and power over the development of reward strategies, as it would be more tailored to local needs, priorities and purposes. Although on the other hand, those who are in favour of retaining a national focus to wage negotiation and pay determination argue that national pay can be easier to manage, less costly for individual hospitals, more time-efficient, allows greater capacity for national budgetary control, and can provide the fundamental support for a structured career outlook for health workers in the country. It is also frequently argued that trade unions and professional association bodies are more in favour of the national wage setting rather than local wage setting because it means they can focus their efforts in one place and empowers them to keep consistency across their membership. (Grimshaw *et al*, 2007; Buchan and North, 2008).

Public sector hospitals play an important oversight role in OECD countries (OECD's Health Systems Characteristics Survey, 2012). The survey was able to outline the degree of autonomy of public hospitals in wage-setting and recruitment decisions in relation to the governments that manage them. It found that during the past decades, many OECD countries have been through structural reforms that have highlighted the significance of passing on responsibility and increasing the autonomy of hospital management teams at the local level with a view to cultivate more efficient service provision. The Survey suggests that national level negotiations are the main ways of setting wage levels for medical staff working in public hospitals. However, a number of OECD countries found that they provide their public hospital management teams with autonomy over the recruitment of staff. The Survey shows a great number of countries use the combination of centralised national wage setting and decentralised recruitment. What is of particular interest is that 14 countries fix public sector hospital medical personnel pay at a national or subnational level, but then pass on the responsibility of recruitment to hospitals to deal with. The power of hospital manager autonomy in recruitment demonstrates that governments have been willing to hand over certain amount of control over staffing arrangements to individual hospitals, but as long as wage determination is kept at a centralised national level.

The reasons for these differences are likely to include the fact that many hospital workers in the latter grouping of countries are employed in the public

sector, and that there is higher coverage of national representation by professional associations/ trade unions than in other sectors.

3.11 Nurses' pay

Pay has been associated with one of the causes for nursing shortage in the UK (RCN, 2017; NMC, 2017). In China, similar results found pay has impacted on nurses' recruitment and retention in China (Hoffman & Woehr, 2006; Li *et al.*, 2011; Chen *et al.*, 2015). It is common to find nurses in China are categorised into two types: *bianzhi* nurses and contract nurses. A *bianzhi* nurse has a continuing contract and is guaranteed a lifetime employment by the government, and usually enjoys extensive benefits; whereas a contract nurse is usually recruited by the hospital and has none or reduced benefits (Shang *et al.*, 2014). Such differences in employment and the inequalities in benefits and pay between *bianzhi* nurses and contract nurses are found to affect nurses' commitment, turnover and job satisfaction (Chan *et al.*, 2013; Zhang *et al.*, 2014; Shang *et al.*, 2014). Studies looking at the relationship between rewards and Chinese nurses' work attitudes are very limited. This research will aim to find out how Chinese public sector nurses' pay are determined and how nurses in the case study hospital feel about their pay.

3.12 Chinese nurses at work

The first Chinese Nursing Association committee meeting in 1914 has set the foundation of nursing care in China (Wong and Zhao, 2012). With the fast economic development taking place in China, demand in health care

increases. Nursing role in China has evolved from merely implementing doctor's orders in hospital to providing services to all people who need them, in clinical environments and communities (Wang, 2016). According to The Chinese MOH, in 2012, the number of registered nurse in China has reached 3.49 million, which equals about 1.85 nurses per 1,000 populations in both urban and rural China (OECD, 2012). 98.2% of registered nurses in China are female, 66.5% of whom are aged between 25 to 44. Only 0.1% of all registered nurses have a postgraduate degree, 8.7% have a university degree, 43.5% have a college degree, 46% have a technical secondary school qualification (NHFPC, 2012). The number of nurses with undergraduate and postgraduate degrees in China has been on the rise since 1900, for the first time in 2004, a doctoral education in nursing was introduced (Tao *et al.*, 2012). One unique feature of Chinese health personnel is that China has more doctors than nurses, and the vast majority of nurses in China work in public sector hospitals.

In 1914, at the first Chinese Nursing Association committee meeting, Zhong Maofang suggested translating the English word 'Nurse' to *hushi* (护士). It was then approved at the meeting and the word *hushi* has been in use since. In China, the term 'nurse' refers to one who holds a Qualification Certificate of Speciality and Technology (*《专业技术资格证书》*) and a Nurse Practicing Qualification Certificate (*《护士执业证书》*). In 1996, the Chinese MOH introduced and implemented an exam for Nurse Practicing Qualification Certificate (*《中华人民共和国护士执业证书》考试*), anyone who wished to become a nurse must pass this examination. Qualification Certificate of

Speciality and Technology is issued by the Chinese Ministry of Human Resources and Social Security, and the Chinese MOH, to those who pass the exam, and only with this certificate can one go on to apply to become a registered nurse, and subsequently receive the Nurse Practicing Qualification Certificate, issued by local government health authorities (Wong and Zhao, 2012; Wang, 2016). Unregistered personnel are not allowed to take up nursing jobs in China.

The aim of the exam is to evaluate whether candidates possess nursing knowledge as well as work capability. The exam adopts a national exam system, whereby it follows a unified outline and examination paper, as well as a unified passing standard. Nurse Qualification Certificate is an essential document required by Chinese health organisations during recruitment. The certificate is issued by the relevant government authorities once candidates pass the exam. The exam consists of two parts: professional knowledge practice and practical ability. Candidates have to pass both parts in one sitting to qualify. Candidates can only apply to take the exam if they hold as a minimum a diploma from a recognised General Secondary Health (Nursing) School. Nurse Practicing Qualification Certificate (*《护士执业证书》*) is a legal document in China (MOH, 2008c). It is only possible to gain employment after the certificate is issued and registered (MOH, 2005b). Findings from You *et al.* (2013) provide empirical support for China to increase the number of baccalaureate prepared nurses. It is important to provide ongoing access to higher education since many nurses attained more education over time. Most of the gain was from initial secondary

education to highest education as associate degree. Graduating half of new nurses from secondary school programs is not a quick way to qualify more baccalaureate-prepared nurses (Aiken *et al.*, 2009). Whereas moving basic nursing education to postsecondary levels would allow more nurses to obtain baccalaureate qualifications over time. With the rises of complexity of hospital care and the expansion of nurses' roles in community care, a more educated nurse workforce becomes even more crucial (You *et al.*, 2015).

The China Social Welfare Foundation, the Nurse Caring Plan along with a number of groups jointly released a White Paper on the current development of the Chinese nursing group in May, 2017 (The White Paper, 2017, China). The White Paper published findings from questionnaires, interviews and on-site visits. The report received 51,046 valid questionnaires from in-service nurses, 168 valid questionnaires from retired nurses, and 1,008 valid questionnaires form the public. The report also included findings from twenty-two on-site visits and interviews, and thirty-six face-to-face interviews, telephone interviews. The aim of this study was to gain a thorough understanding of the current situation of Chinese nurses in relation to their general work conditions, their health, their psychological state, and their occupational development. Through analysing the differences and factors of nurses by, for example, sex, age, qualification and the type of hospitals they work in, the study wished to find the main causes behind low retention among nursing staff.

The report found that about 79% of nurses working in health organisations suffer injuries from sharp tools and over half have psychological trauma, the two leading occupational hazards. It showed that violence against medical workers and occupational injuries are top concerns among them. Some 68.5% of those who left the occupation had the same experiences. In addition to mental scars (51.2%), other hazards identified include noise, exposure to ultraviolet light, dust pollution and infection. The report said 38% of employers do not provide effective preventive supplies for nurses and 44.6% pay little or no attention to risks posed to nurses. It also found that 41.2% of nurses have been the target of aggressive behaviour from patients or their family members in the past year. According to the report, 80.7% said they highly value being respected and 92% thought they have low social status. Over 83% said they did not feel they were respected by patients and 90% saw their job as not appreciated by society. Managers need to pay more attention to the psychological requirements of nurses and should help them better cope with mental stress, it was added.

Most studies (Loher *et al.*, 1985; Lu, White and Barriball, 2007; Sun *et al.*, 2009; Liu *et al.*, 2012; Chen *et al.*, 2015;) concerning attitudes of health personnel have emerged from the fields of mental health and geriatrics. Not many studies have looked at the attitudes of health professionals towards the nursing process. Bowman *et al*. (1983) looked at nurses' attitudes towards the nursing process suggested strongly that special training of nurses, through a structured educational programme, improves the attitudes of nursing staff towards the nursing process. It has been shown that attitudes

may be changed in a positive direction with education for relatively short periods of time (Morrison and McIntyre, 1969). It can be assumed that repeated confirmation of the values accepted within groups due to the primary education is necessary if a positive attitude to changes such as the nursing process is to be maintained. The maintenance of the values underlying this particular change is dependent on the attitude and involvement of the group leader, such as nursing officer or charge nurse. Other elements that may affect attitude changes include: workers recognising problems happening in their work activity and wanting to change it, the social system within any unit (Kelman, 1969), organisational development (Adam and Bond, 2000), leadership patterns of unit heads (Ribelin, 2003; Curtis and O'Connell, 2011; Tennant, 2015) and intervention techniques within smaller groups in the unit (Back, 1974; Bowman, Thompson and Sutton, 1983). It is also found that the institutional influences do play a big part in affecting nurses' attitudes (Bendall, 1971, Tzeng, 2002; Aly and El-Shanawany, 2016).

3.13 Nurses in Chinese public hospitals

Although it seems on paper that China has the second largest nurse labour force in the world, the USA being number 1 (Xu, 2003), the actual nurse per person ratio drops right down. Of the 3.49 million nurses in China (MOH, 2017), this gives about 1.85 nurses per 1,000 population in both urban and rural China (see Table 3.4), compared to 8.2 nurses per 1000 population in the UK, 10.5 nurses per 1000 population in Japan, 11.1 nurses per 1000

population in the USA, and 16.5 nurses per 1000 population in Norway (OECD, 2012).

At the moment in China, nursing education systems delivers five main qualifications, including vocational qualification, college degree, bachelor degree, master degree and doctoral degree. Out of these, the undergraduate nursing qualification has become the most widely used form of nursing education (Gao *et al.*, 2017). In the case study hospital, there is only one nurse with a postgraduate degree. Both the head of the hospital and the head nurse explained that the minimum recruitment qualification requirement is a college degree. The hospital has recruited nurses with undergraduate university degree and sometimes postgraduate degree, but having highly qualified nurses (those who have university or postgraduate degree) have not proven to be necessary.

1.83 million nurses work in hospitals in China which includes 1.62 million who work in public sector hospitals and 0.2 million who work in private hospitals (MOH, 2012). In the past, those who pursue a career in the public sector in China were attracted by the security of lifetime employment, steady income, housing, pension, health care and other benefits. Since the economic reform in 1979, China remained largely a planned economy and the Chinese government had a special employment system in which employers were asked to simply follow the decisions made by the government over employment. For each public sector employer, the government decides the number of staff it recruits, which is known as

'*bianzhi*'; jobs that fall under this category comes with a lifetime employment guarantee and all the other associated benefits. Employers can not dismiss employees who hold these 'iron rice bowl' positions because these are protected by the government. Posts that are not within '*bianzhi*' are referred to as '*bianwai*' or 'contract-based jobs/fixed-term contracts' (*hetongzhi*). The associated employments conditions and job-related benefits of these posts can be decided by individual employers. Until about 1978, most Chinese had a 'iron rice bowl' job, but with the ongoing economic reform taking place in China, there is a clear increase of contract-based jobs (Ang, 2012).

Table 3.4 Nurses ratio per thousand people in China

Year	1949	1980	1990	2000	2012
Total number of nurses	37,800	465,798	974,541	1,266,838	2,496,599
Total percentage/thousand people	0.06	0.47	0.86	1.02	1.85
Urban cities	0.25	1.83	1.91	1.64	3.65
Rural areas	0.02	0.20	0.43	0.54	1.09

(Source: Chinese Health and Family Planning Statistics Yearbook 2012, NHFPC)

In the late 1980s, with the open-up policy being implemented in a number of Chinese coastal cities, some hospitals in those areas started to hire contract-based nurses to help relieve the nursing shortage in China (Wang 2008). The Chinese government does not regulate the proportion of '*bianzhi*' nurses compared to contract-based nurses in its public sector hospitals, overall, new joiners are mostly recruited under '*hetongzhi*' unless they hold a Master's degree or higher in nursing (DeNoble, 2012). The head of HR at the case study hospital said:

> "We recruit nurses from the market. We have requirements for qualification – in recent years, the lowest qualification we accept from applicants is a college degree; we might increase the level of qualification to university degree in the near future ……since 2007, we have hardly recruited any nurse on permanent contract; nearly all of the nurses we have recruited are contract-based nurses. This is a pan university requirement – unless the candidate holds a doctorate degree or above, no permanent contract would be given."

Shang *et al.* (2014) suggests that Chinese university hospitals recruit significantly more contract-based nurses than provincial hospitals and municipal hospitals. Generally, about half of nurses in China's comprehensive hospitals are contract-based. The average age of a contract-based nurse is generally younger and they have less professional working experience.

One of the known factors which has become a global issue is nursing shortage and nurses' high turnover (Kingma, 2001; Han *et al.*, 2015; Lyu, 2016; Yang, 2017). It was estimated that China had a shortfall of 346,000 nurses in 2012 (Wang *et al.*, 2013). At the same time the Chinese nursing force faces great challenges in recruitment and retention as the labour market for nurses has changed since China entered the World Trade Organisation. An increasing number of Chinese nurses have chosen to work in western countries where they receive better pay and have more opportunities, this job mobility is a result of more relaxed immigration policies

(Ho,1995; Xu, 2003). But for those who work within the country, competition in the labour market has become ever so challenging. This is caused by a number of facts - nurses are oversupplied in China, especially graduates of secondary nursing schools. Chinese nurses prefer to work in urban cities rather than in the countryside which has caused a major shortfall of nurse numbers in rural communities. Most hospitals in urban cities have changed their recruitment policy in favour of graduates with college and baccalaureate nursing qualifications as a measure to improve nursing care quality. All these add further job pressure to the graduates of secondary nursing schools (Xu, 2003). Other known work-related factors that have been associated with Chinese nurses' turnover intention include high job demand, perceived autonomy at work, support from superior or peers, and job satisfaction (Aiken, 2002; Han *et al.*, 2015; Yang *et al.*, 2017). There are also factors associated with personal aspirations and characteristics, such as professional self-image, resilience and work-life interference (*ibid*). As a result, turnover among new graduates are high, and overall, the cost for employers due to the volume of turnover from the profession is high. As such, it imposes severe pressures on the Chinese healthcare system.

It is also argued that nursing in China is in the early stages of its development towards achieving the status of a fully-fledged profession (Xu, 2003) based on the eight criteria suggested by Pavalko (1971). These include theory, relevance to social values, training and education period, motivation, autonomy, commitment, sense of community, and code of ethics. These elements will be explored through the questions in the questionnaire

designed for this research, and the findings will be discussed in later chapters. What is more, the Chinese nursing force has been described as the handmaiden to medicine. Nursing alone does not have a professional organisation in the real sense of a trade guide to protect its interests and can therefore be a vulnerable occupation.

3.14 Chinese nurses' education

Nursing and nursing education began nearly two hundred years ago in China (Wong, 2012). Along with the progress China has made in its nursing practice and education system during the last few decades, along came many challenges. Despite having the second large number of nurses in the world, it is argued that the Chinese education system lacks the ability to train and certify high quality nurses. These are reflected in the way nurses are trained at school, for example, nursing practices focuses on disease treatment, not disease prevention or health rehabilitation. The nursing curriculum uses a biomedical model rather than a nursing-oriented model. Some accuse China of lacking both the capacity and the education system to train and certify high quality nurses, especially well-educated nurses and those with advanced professional titles (Wang, 2016; Wang *et al.*, 2013).

The reasons given behind why many Chinese nurses lack professional competence was a result of limitations in nursing schools, such as unqualified teaching faculties, and outdated teaching approaches and materials. These limitations make the Chinese nursing education system lack the use of an evidence-based approach, standardised curriculum, and

research opportunities; further to these limitations, the absence of employer-funded nursing professional development programmes, the heavy workload, and an old-fashioned public view of nursing roles make very few want to study nursing, and this, ultimately means low nursing retention rates and long-term shortage of nurses (Wang, 2016). The Ministry of Education along with the central government had been working on improving the overall quality in Chinese higher education. The Ministry of Education initiated a nationwide series of Higher Education Quality projects in 2003. Higher education institutes had access to funding to ensure the delivery of the projects. A number of nursing projects were funded, including nursing competency training models, nursing demonstration laboratory centres, and nursing speciality development. These projects focussed on the construction of humanistic education framework, the improvement of nursing students' critical thinking ability, the progress in evidence-based practise and the overall better integration of theory and practice (Wong, 2012).

A typical path for a Chinese person to obtain a nursing degree usually takes three to five years. This includes professional education, examinations and clinical internships. However, not all students studying nursing chose it as their first choice. This is largely caused by the setup of Chinese education system. In China, all students wishing to attend universities need to sit the yearly National Higher Education Entrance Examination. The scores of this exam are used to determine whether they can get into universities, and which course they can study (Wong, 2012). For example, when a student passes the lowest entrance benchmark for a university, this student may or

may not be eligible to enrol in the courses they have an interest in, depending on the number of the number of applicants and the university's admission plan that year, and of course, the student's actual exam results. A small study looking at 140 students showed that, 30.1% chose to study nursing because they wanted to enrol at the university they were admitted into, and 29% chose nursing based on their exam results (Zhang & Petrini, 2008). This shows not all students studying nursing programmes chose nursing as their first choice, thus, students' orientation to nursing is compromised and was ultimately affect their decision to stay in nursing.

3.15 Changes and expectations of Chinese nurses' work

The Vice-Prime Minister of the Chinese MOH, Ma Xiaowei, outlined the future of nursing in 2011. Ma (2011) stressed that nurses should provide services to all people who need them, and so nurses need to work in clinical environments, as well as in communities, providing care and knowledge to prevent rather than just to cure. The holistic concept of care is to be used in order to allow nurses to provide care and manage care transition from one level to another, in a case management approach. This poses not only new challenges to the health system but also pressure on individual nurses. The content and pedagogy of the curriculum is crucial in developing nurses to be ready for the changing healthcare demands in China. As the plan to shift from disease treatment to health prevention and rehabilitation, nurses need to use their gained professional competence in health surveillance, health education and promotion (Wong, 2010, 2012). In 2012, the good quality of nursing service action advocated by the MOH of China stressed that all

nursing activities should be performed with the patient-centred principle. Nursing care activities are centred on the patient, and the above definitions and policies reflect that quality improvement should be based on patient needs and expectations. However, the demands and expectations directly expressed by patients are not always reasonable, which may interfere with nursing care content, and quality improvement is difficult to achieve (Wang et al., 2017).

The overall aim behind the government's changes is thought to introduce affordable, accessible, available and quality health care for people in China. The Chinese government has set specific targets to implement the comprehensive national healthcare insurance in 2011 and to achieve the aim of accessible and available care to all by 2020 (MOH, 2009a). Nurses are in a crucial position in supporting the changes, for example, in the performance evaluation guide for hospital performance (MOH, 2008b), a section dedicated to 'nursing quality assurance and continuous improvement' was included. It clearly laid out specifications for nursing practice and development. From the practice end, nurses are expected to provide patient-centred and holistic care supported by an effective system of guidelines that clearly allocate responsibilities and work flow, management by objectives, regular nurse rounds and case conferences. The performance evaluation guide also requires that the total number of nurses should not be less than half of the total health workforce in the hospital, and the nurse-to-bed ratio should be at least 0.4–1.

The definition of a nurse in China is provided and protected by The Nurse Act (Liu and Zeng, 2008 a, b). The Nurse Act demands the mandate for nurse registration to have clear specifications for education and work involvement requirements. The Act's definition of nursing is not only in line with the international expectations, but also details the rights Chinese nurses have. Such as, the right to equal work and equal pay, the right to continued education and promotion competition, and the right to challenge medical prescription when in doubt.

It may not sound surprising to you if someone told you a nurse's job usually means long hours and low pay, but for Chinese nurses, there are more perceived characteristics. A study looking at Chinese nursing students' culturally related learning styles and behaviours (Wang and Greenwood, 2015) found that Chinese nurses learning styles are significantly more subtle and complex. It is believed that much of the Chinese society is shaped by Confucian philosophy. Confucian philosophy stresses the value of harmony. It encourages individuals to accustom to collectivism, to control one's emotions, to avoid conflict, to maintain inner harmony and to put the collective interests above all (Kirkbride and Tang, 1992). The lack of personal confrontation and the stress on harmonious interpersonal relationship among Chinese workers are shaped by the value of Confucian philosophy. Chinese nurses and nursing students turn to observe the following behavioural principles: respect for authority figures and keeping harmony; communication is often implicit and indirect, a lengthy and complex internal thought process is conducted before taking part in a conversation;

and keeping one's opinion to oneself or close family and friend (Wang and Greenwood, 2015). These behavioural principles are very much directed by Confucianism, which emphasis on the value of harmony, asking individuals to accustom to collectivism, to control one's emotions, to avoid conflict, and to maintain inner harmony (Kirkbride and Tang, 1992; Tang, 2012). Respecting authority figures, such as teachers and managers, do as one is told, is a Confucian perspective and the tradition of absolute respect shown to others. This not only enables closer relationship to be nurtured but more importantly helps to maintain harmony. The image of Chinese nurses are often described as 'White Angles' for their generous contribution to public health, and there has been a growing recognition of nurses' value and importance to the society (Liu *et al.*, 2004).

3.16 Case study hospital background

The case study hospital is located in Xi'an, the capital of ShaanXi, located in the western region of China. Xi'an is one of the oldest cities in China and was one the most important cities of China before 1000 AD, serving as the capital city of thirteen dynasties from 221 BC. It is also the starting point of the Silk Road and home to the Terracotta Army of Emperor Qin Shi Huang. Since the 1990s, Xi'an has become the cultural, industrial and educational hub of the central-northwest region of China, as part of the economic revival of inland China especially for the central and northwest regions. There are 9 districts and 4 counties under the ministration of Xi'an, which currently holds sub-provincial status. In 2015, Xi'an has a population of 8.83 million (Xi'an Statistics Bureau, 2017). It is the most populous city in Northwest China.

Figures published by the Chinese National Bureau of Statistics figures showed that there are 1,085 hospitals in ShaanXi province, with 110,680 registered nurses looking after a population of 38.1 million (National Bureau of Statistics, 2016d). Xi'an, being the provisional capital, has 292 hospitals, over 86,000 health technical personnel, and 56,300 hospital beds (ShaanXi Government portal, 2017).

In 1989, the Chinese MOH introduced a new public hospital accreditation system which classifies hospitals into three different grades based on, for example, 'hospital functions, missions, facilities, professional construction, healthcare quality and safety, scientific management. Within the highest grade, Grade 3 hospitals are further classified into four classes - Top, A, B and C, according to their accreditation scores. All third-grade hospitals shall have more than 500 beds (Li *et al.*, 2014, p.2). At the end of 2012, Chinese government had a total number of 23,170 hospitals, 15,021 of those were comprehensive hospitals, 595 comprehensive hospitals of those were listed as Grade Three Class A hospitals - Grade 3 Glass comprehensive hospital is the highest standard hospitals in China (NHFPC, 2013).

The case study hospital was founded in 1937. It is a large Grade Three Class A listed modern comprehensive hospital entrusted by the MOH featuring clinical practice, medical education and research, disease prevention and health care. It is worth noting, in China, hospitals are re-evaluated periodically, and the reassessment of a Grade Three Class A hospitals is every four years. This ensures that tertiary hospitals maintain

their high standards of operation. If a Grade Three Class A hospital fails in the re-evaluation, it loses its title and is required to reform its institution and then apply for a new hospital grade evaluation. Generally, hospital grade re-evaluation assesses the 'hardware' (environment, facility, documentation) and 'software' (structure, management, clinical pathway, regulation and implementation) of a comprehensive hospital system (Fang, 2017)

It is the State Clinical Experiment Organisation on Medicine, MOH International Emergency Rescue Centre Hospital, World Health Organisation Baby Friendly Hospital, MOH Baby Friendly Hospital, and Best Hospital in ShaanXi province. The case study hospital has twenty-nine clinical departments, twelve medical technical departments. It also features twelve research institutes and twelve clinical teaching and research sections. The hospital had 1,000 beds and on average it provided inpatient services to over 20,000 patients every year and an outpatient and emergency service to over 500,000 patients every year. It employed around 2,450 employees, including 94 professors, 180 associate professors and 551 high-rank medical staff. 80% of the employees working for the hospital were professional medical staff; employees that held PhD, master's and undergraduate degrees made up a total percentage of 61.2; the hospital had fifty-two senior professors who had delivered great contributions to academic researches and received special government allowances. The case study hospital employed a total number of 1,153 nurses, 326 of whom were on permanent contracts, also known as '*bianzhi*' nurses and the rest were employed on fixed-term contracts, knowing as 'hetongzhi' nurses (Hospital internal documents).

3.17 Conclusion

This chapter has attempted to set the scene of the case study, including introducing the changing landscape of industrial relations in China, Chinese pay determination process, Chinese health reform, Chinese health service personnel management, with a focus on Chinese nurses' at work and the related labour issues.

China has seen major changes in its employment system during the past decades, from its iron-rice bowl era which started in the 1950s (Cooke, 2005, 2009, 2011; Frear, 2012) to a market-oriented labour management (Taylor, Chang and Li, 2003; Cooke, 2009; Frear, 2012). During this time, once the lifetime employment which guaranteed job security and benefits, but with little flexibility or mobility to change jobs, was replaced by an increasingly market focussed labour management system. The new system was backed by the first Labour Law passed in 1994, and a set of new legislation including the Labour Contract Law in 2008 (Brown, 2010). This set of legislation has provided a highly detailed regulatory framework covering issues of general provisions, establishment of labour contracts, implementation and amendment of labour contracts, termination and ending of labour contracts. It also included special provisions detailing issues around collective contracts, labour hire and dispatch, and non-full-time labour contracts, monitoring inspections, legal liability, and supplementary provisions (Labour Contract Law 2007). The general provisions laid down the fundamental principles, such as the proposal to improve the labour contract system, to protect the workers' legal rights and interests and to develop harmonious and stable

employment relationships (Article 1, Labour Contract Law 2007). The Labour Contract Law is a distinct improvement on the existing legal framework regulating employment relations (Warner, 2009; Warner and Zhu, 2010), and it has enhanced the security of employment.

Researchers have found increasing trend in China that human resource management are starting to adopt Western HR practices (Child, 2009; Zhu, Warner, 2009, 2012; Warner and Zhao, 2011; Tang, 2012; Frear, 2012). Along with the discussion of the Chinese industrial relations practices, the introduction of the administration and the management of hospitals, and of the Chinese health service personnel management have demonstrated that the economic and social system in China are similar to that of western countries (Li *et al.*, 2012; Wang, 2012; Frear, 2012), and therefore employment issues of Chinese workers can be analysed as any other workers.

With that in mind, this chapter went through and discussed how Chinese health reform since the 1950s have changed the way the state manages its hospitals and relevant personnel, in order to improve service performance and reduce budgets (Ho, 1995; Sussmuth-Dyckerhoff and Wang, 2010; Shen and Jiang, 2010; Yip *et al.*, 2012). Generally speaking, the overall Chinese health service is under-funded by the government and the distribution of health resources is unbalanced among different regions (NHFPC, 2013). The pressure of health service funding has led to dramatic institutional changes in Chinese hospitals, such as marketisation (Gu and Zhang, 2006; Zhang *et al.*,

2014). Chinese public sector hospitals are the predominant deliverer of inpatient care to over 1.3 billion people. These hospitals account for approximately 80% of all of China's hospitals, and more than 90% of its inpatient hospital beds (National Health and Family Planning Commission of the People's Republic of China, 2012). The case study hospital is owned by the government and faces budgetary constraints, and pressure to use marketisation methods as the solution to pay its staff. The pay system of the case study hospital, especially its bonus pay system is complicated. In later chapters, details will be provided as to how nurses feel about such pay systems.

This chapter went on to look at the current nursing education in China and how that has an impact on the nursing labour market. The perceived characteristics of Chinese nurses are that they turn to have respect for authority figures and like to keep harmony; and keeping one’s opinion to oneself or close family and friend (Wang and Greenwood, 2015). These perceived characteristics are interesting cultural background which may provide some explanations to some of the surveyed questions. The general account of the case study hospital, including the history and the size of the hospital, the number of doctors, nurses it employs has provided a sense of the scale of the case study hospital, including its performance in relation to hospitals in China. Thus further sets the scene for the case study in the later chapters.

Chapter Four

Research methods

4.1 Introduction

This chapter considers the theoretical perspectives and methods which have shaped this thesis. Research is about “seeking through methodical processes to add to one’s own body of knowledge and, hopefully, to that of others, by the discovery of non-trivial facts and insights” (Sharp, Peter and Howard, 2003, p.8). Research methods can be employed when undertaking fieldwork research in order to obtain empirical data and that can be utilised to address specific research questions related to our study of industrial relations and HRM. This research follows Goldthorpe’s monograph (1968) which looked at the relationship of car workers to their working environment. The methods they employed were largely determined by the aim of their study: to give some account of the attitudes and behaviour of ‘affluent’ manual workers in the context of their industrial employment; as well as how the attitudes and behaviour could best be explained. They believed that the way in which the workers to be studied determined interviews and field investigations were the main research instruments.

The aim of this study is to find the relevant factors of nurses' attitudes to and at work, including the separate but related hypotheses – the nature of the profession and changes in terms of management and training, the nature of the work situation including contracts and pay determination and the nature of work relations as they impinge on nurse status including relations with co-

workers and patients. So it has adopted the methods used by Goldthorpe including semi-structured interviews and field investigation. It is further compensated by using questionnaire as a key data collection method, along with documentary analysis and observation. Both questionnaires and semi-structured interviews are used as the main source of data collection. Overall, the thesis followed Goldthorpe's study of car workers in the 1960s. Goldthorpe explored workers' pay and conditions, workers' relationship with work, relationship with their firm, relationship with their co-workers and relationship with their union. But where the studies are clearly divergent is that car workers were strongly unionised and that they were workers who made cars; whereas nurses in this study worked not only with their co-workers but dealt with patients in their everyday work. So through adopting Goldthorpe's methods of using survey and interviews, this study not only looked at nurses and their work but also nurses and their relationships with patients, management and co-workers.

To provide a logical and convincing examination of nurses' attitudes towards their work, issues around research methods need to be evaluated, discussed and justified. Not only because there are ethical elements in studying health service and Chinese nurses, but also this is relatively under studied area of industrial relations. In the same way, it is important to address the principle of selecting study groups, and the collecting and handling of the data. To achieve the above purpose, this chapter begins by introducing research theories, and research methods for social sciences for industrial relations. 330 questionnaires were handed out to all nurses working in the twelve

clinical departments which were chosen to be surveyed. Semi-structured interviews were conducted with the head of the hospital, the head of HR, the hospital Head Nurse and twelve departmental head nurses from twelve surveyed clinical departments in the hospital. This enabled the research to obtain a relatively wide view of the subject studied. Through these methods, the aim was to gain a more rounded understanding of Chinese public sector hospitals' nurses' attitudes towards their work, in particular, what and how are their attitudes affected.

Expanding on the above, this chapter will explain in detail the research methods adopted and the rationale behind using them. Firstly, research theories that have informed the approach of this research will be elucidated. Critical rationalism is the philosophy of the Anglo-Austrian philosopher Karl Popper. Popper made major contributions in two distinct areas of philosophy, the philosophy of science and the philosophy of sociology and politics (Ormerod, 2009). Following on from Hume's original idea of 'problem of induction', Popper demonstrated how using 'falsification' as the differentiating characteristic of science solved this problem along with the demarcation problem. Popper took the view that: "In matters of the intellect, the only things worth striving for are true theories, or theories which come near to the truth--at any rate nearer than some other (competing) theory, for example an older one" (Popper, 1963, p.22). He says empiricists assert that observation must be the ultimate source of our knowledge. "Every witness must always make ample use, in his report, of his knowledge of persons, places, things, linguistic usages, social conventions, and so on. He cannot rely merely upon

his eyes or ears, especially if his report is to be of use in justifying any assertion worth justifying. But this fact must of course always raise new questions as to the sources of those elements of his knowledge which are not immediately observational" (Popper, 1963, p.30).

The decision to employ a case study method using a combination of qualitative and quantitative techniques will be rationalised. Bias, validity, reliability, and ethics are discussed and justified, in relation to the designing data collection and analytical processes. This chapter also introduces the research methods used for the designing, data collection and data analysis stages of the case study. It explains the rationale behind each method used in the research as well as outlining the associated opportunities, difficulties and limitations.

It is believed that the methods which researchers turn to use cannot always address all research questions. This chapter will examine the advantages and disadvantages of each method approach and give reasons to the rationale for the methods that had been used. This chapter will first look at research methods for studying social sciences in general and followed by a closer look at methods used for when studying Industrial Relations. It will then discuss the process of this study – starting from the research design, fieldwork to data analysis. Issues and limitations of the study will be discussed and explained.

4.2 Research methodology

This research is based on evidence knowledge. Scientific inquiry adopts a realist ontology and positivist epistemological perspective, thus implying that other positions exist. Positivism leads to a belief that the methods and procedures of the natural sciences are appropriate to the social sciences. It also entails a belief that only those phenomena which are observable, being amenable to the senses, can validly be warranted as knowledge. What this means is that phenomena which cannot be observed either directly through experience and observation or indirectly with the help of instruments do not exist. Such a position rules out possibility of mixing 'feelings' or 'subjective experience' into the world of social scientific knowledge if they cannot be presented as observable. This aspect of positivism is often referred to as the doctrine of phenomenalism or empiricism. Positivism is also used to involve a particular stance in relation to values. This can be interpreted in two senses: the need to purge the scientist of values which may reduce their objectivity and therefore weaken the validity of knowledge; and, secondly to draw a distinction between scientific issues and statements and normative ones (Bryman, 1988).

A number of authors describe both ontological and epistemological approach as being on a continuum with realist/positivist and relativist/constructionist at polar ends (Ballinger, 2006; Finlay, 2006b； Andrews, 2012). Unlike the realist leanings of quantitative research, qualitative approaches may also adopt a more relativist stance (Gilson, 2012). Such approaches emphasise that individual experiences and

perceptions of the world shape how individuals conceive the world and as a result of these unique vantage points, ‘reality’ can be considered multiple (King and Horrocks, 2010). Where on the continuum a particular approach sits will depend on the epistemological stance of the researcher. The key difference is, that to varying degrees, qualitative research approaches reality as varying in construction and interpretation. What qualitative studies share is their interest in meaning and the human experience. However, it is their acceptance of the multiplicity of truth which Miller and Crabtree (2000) underscore as the strength of qualitative approaches, providing them with the capacity to explore areas of health care not amenable to reduction or quantification, including social influences and personal experience. Lincoln and Cannella (2004, p.7) support this, arguing that whilst there are similarities in the way people experience illness, an array of social factors such as gender, class, race and ethnicity lead to unique if “subtle” differences and that an awareness of this is vital if health care is to be “sensitive to social needs”.

Porter (2007) contests the view that realism is an unsuitable position for qualitative researchers, arguing that it is positivism and its search for universal truths, not realism that is unsuitable. Believing in a single reality does not rule out the possibility of there being a plethora of differing yet valid perspectives within a single, complex reality. In this respect, Porter (2007, p.82) argues that realism should not be synonymous with simplistic notions of “unilinear causality”, but “rather it should be ‘what works for whom in what circumstances?” The paper makes direct reference to work by Hammersley

(2004) to support the argument and in doing so appears to be embracing subtle realism. From this position, it is argued that there is a reality open to human exploration and that knowledge about the world can be gleaned despite the subjective nature of human perception (Mays and Pope, 2000; Duncan and Nicol, 2004; Hammersley, 2004). Given the fallibility of human perception, whist it is accepted that knowledge derived on such an imperfect basis can never be considered with certainty, Murphy *et al*. (1998. p.iii) contend that accepting knowledge formed on the basis of plausible, credible evidence, which provides "knowledge about which we can be reasonably confident", is worthwhile.

Others liken subtle realism to science and to positivism. Finlay (2006, p.324) then goes on to explain the relativist standpoint which she earlier describes as tending "to value more reflexive modes which demonstrate the possibility of multiple understandings and interpretations". Whilst there is an apparent disagreement as to whether subtle realism equates to positivism, this is perhaps due to the confusion as to whether subtle realism is considered ontological or epistemological in nature. Duncan and Nicol (2004) briefly note that the ontological basis of subtle realism has been criticised, and Banfield (2004) provides a critique of subtle realism, within which he identifies Hammersley's (1992) description of subtle realism as being largely epistemological, namely discussing how we know what we know as opposed to what the nature of reality is.

My industrial relations background has engendered within me a strong belief that there is a single reality whilst my experiences of conducting evidence and knowledge based researches have opened my awareness to the complexity and seeming multiplicity of such a reality. I, like Porter, take the view that being a realist does not necessitate a positivist epistemological approach, as whilst ontological and epistemological aspects of research are related they are not synonymous. This is reflected in the diversity of qualitative research where the similar epistemologies are undertaken from differing ontological standpoints. For example, ethnographers may approach the study of cultures from a constructivist/interpretivist stance, where meanings and values are socially constructed and therefore interpreted, or a realist/objectivist view, where the researcher is positioned as observer of a fixed social reality which exists in spite of the researcher (Hammersley, 2004). Instead, subtle realism is adopted as underpinning this thesis because it is most in line with my own worldview, supporting my belief in a single, yet multifaceted reality and the need for rigour in reflecting "as full a picture as possible of the nature of that multi-faceted reality" (Snape and Spencer, 2003, p.20).

4.3 Research methods in studying industrial relations

The concept of methodology is described as "the systematic and logical study of the general principles guiding sociological investigation" (Bulmer, 1984, p.4). Social science studies focus on the rules of individual and groups of human beings' activities. Social science is the "scientific study of human behaviour" (Punch, 1998, p.8) and that the research method for study social

science is “a carefully considered way of approaching the world so that people may understand it better” (Sayer, 1992, p.12). Social and economic context within which people are living in becomes vastly important when conducting social science studies. To understand others properly is no less important than if the social inquiry is scientific because a justifiable methodology in social sciences research is essential to ensure the reliability and validity of its findings (Fay, 1996, p.5). Quantitative research is typically taken to be exemplified by the social survey and by experimental investigations. Qualitative research tends to be associated with participant observation and unstructured, in-depth interviewing. On the surface, questions relating to the advantages and capacities of these two approaches and their techniques would seem to be technical ones, though in fact, philosophical issues feature strongly and relate closely with an increasing interest in the methods associate with a qualitative approach (Bryman, 1988).

This study is based on a case study. Semi-structured interview; questionnaires; and document search were the main adopted methods. The reason for using a combination of qualitative and quantitative approach is because along with using qualitative methods, such as interviews to establish a face to face communication to collect evidence, a quantitative approach is suited for testing realist positions (Gilson, 2012). As Bryman (1984) identifies, it is not often that quantitative, scientific studies discuss the underlying values or belief system which drive their inquiry. Instead, most insight on this has been derived from qualitative publications, which attempt to compare, explain and justify their approach in relation to this dominant

paradigm. However, the two attributes commonly ascribed to a scientific rationale, and by extension quantitative research, are realist and positivist. Concerning industrial relations research, the traditional methods such as case studies are still appropriate and meaningful, because case study work holds a “distinctive orientation in theorization of the labour process and management strategy” (Edwards, 2003, p.18).

4.4 Ethnography

Ethnography is a research process of learning about people by learning from them. It is often used by researchers to understand and describe why a group of people do what they do. This study is ethnographic whose purpose is to investigate the relevant factors of Chinese nurses’ attitudes to work, in order to learn about their relationships and attitudes to work, to co-workers, to patients and to the general terms and conditions of their work. There can be research difficulties if the researcher and those being researched come from different backgrounds, namely that while the words may be the same the meaning attributed to words and phrases can be misconstrued if there is no common bond. Hence an older non-Chinese male researcher may struggle to appreciate the nuances of mainly female, younger, and local Chinese nurses. My background as a young Chinese woman from the locality matched the characteristics therefore helped overcome these problems.

Van Maanen (2009, p.16) claims the purpose of ethnographic research is to attempt to put into writing “what it is like to be somebody else”. Participant

observation, interviewing, and document search are the principal methods used by ethnographers. Participant observation allows researcher to systematically observe and participate in activities of group members in order to personally experience their life. Both formal and informal interviewing allow researchers to identify the meaning that observed patterns of behaviour have for group members (Locke, 2001; Watson, 2011).

Ethnography also reviews supplementary sources of information, such as written reports, visual records, and historical accounts, to gain a full view of the people, and research questions (Roper and Shapira, 1999). Ethnography is one type of a qualitative research. The conduct of all qualitative research is an interactive process of inquiry between the investigators and the participants. Ethnography, phenomenology, and theory research are approaches that fall under qualitative research. Patton (2002) contends that whilst approaches such as these just mentioned, offer invaluable insights into a given phenomenon through the application of unique lenses, not all research questions lend themselves to the philosophical concerns of established approaches. Instead, Patton (2002, pp.135-136) argues:

> "Not all questions are theory based. Indeed, the quite concrete and practical questions of people working to make the world a better place (and wondering if what they are doing is working) can be addressed without placing the study in one of the theoretical frameworks".

When ethnography is used as the methodology of investigation, researchers become the instruments for data collection (Roper and Shapira, 1999; Morse,

1989). The influence of the researcher on the outcome of the study is of concern to ethnographic researchers, as well as to those who question the objectivity of the method. In a study of nurses by Germain (1979), seven dimensions that the researcher must explore in order to achieve subjective adequacy within ethnographic participant observation were listed. These include, time, place, social circumstances, language, intimacy, consensus and validation, and bias.

Time - the researcher must spend enough time in the setting to learn about the people, behaviours, and events and to be accepted as a member of that group. This is not a general rule about the amount of time that the researcher must spend, but there are fieldwork studies that lasted years and others that lasted a few months or only a few weeks.

Place – this refers to the location where ethnographic participant observation is conducted. The appropriate setting is essential to answer research questions. For example, in Fisher and Peterson's (1993) study of operating room staffs' attitudes toward elderly patients, the researchers themselves spent 5 months as participant observers in three operating rooms at one in-patient facility and also interviewed physicians and nurses.

Social circumstances – the researcher can learn through social events, formal meetings and activities in order to gain a complete picture of the research setting and its people. It is found in Kauffman's study (1994) that trust was built with the participants when she joined them in various social

events. In that particular study, she was young and white, her participants were elderly and black. By taking part in social events with her participants, the researcher overcame the barriers caused by age and ethnicity.

Language – when studying one's own culture and subculture, language may not be an issue. However, conducting ethnography in researcher's own language may cause the researcher to miss certain communication patterns due to the familiarity and insensitivity to nuances. It is argued that lack of knowledge in a language may benefit the study. Field (1989) studied Iranian emigrant women, although herself not an Iranian, was able to gain details of the personal lives of the emigrant women, that were not shared with someone from Iran. It was thought that the Iranian women were not comfortable sharing their personal information with people from their own culture.

Intimacy – to be an ethnographic participant observer, one has to be immersed in the culture, the event, and the phenomenon (Gans, 1984). But settings and its participants can put restrictions and limitations on what you could see, for example, gender differences means attendances to certain events are limited.

Consensus or validation of data and interpretations of the data – researcher can check the interpretation with that of participants in the study. Researchers can also check their observations and interpretations through informal interviewing.

Bias – this is something all researchers must be aware of, as it may influence data collections, interpretation of findings, and description of findings. Potential bias caused by a researcher's values, belief, personality, and knowledge are more obvious, compared to bias of the participants towards the researcher. This can be shown through restricting access to information or providing wrong information because the researcher is not a member of their group. This form of bias could be overcome by maintaining an open, non-judgemental attitude towards participants, as well as being clear about what your role is, and how the information gathered will be used.

To help overcome potential issues around ethnography, many recent studies on Chinese nurses are carried out by scholars in nursing or nurses themselves, such as the studies by Yao *et al.* (2012) and Zeng (2009) on job stress among nurses. The study of nurses' work pressure by Yang *et al.* (2017); care quality and patient satisfaction in China and Europe by You *et al.* (2013), and Chinese nurses' job satisfaction (2014) by Zhang *et al..* Authors of these studies have managed to overcome the potential ethnographic problems.

In this research, I explored and overcame the potential ethnographic problems listed above. I am a young Chinese woman, who has lived in the city where the case study hospital is located for over twenty years. From my grandparents' generation, most of my family members worked in the Chinese public health sector. As such, both of my parents also worked in the Chinese public health sector prior to retirement. I have a good grasp of and am

familiar with the general health system in China through formal learning, as well as informal conversations with employees working for the Chinese health sector. This advantage has enabled me to gain first-hand, real documentations, stories and trust from participants of the research. Moreover, my role in conducting this research and the purpose of this research was made clear to all participants throughout the study.

4.5 Research strategy and design

Research strategy requires “certain techniques to yield data with specific manipulative and fact-finding operations” (Bulmer, 1984, p.4-5). It is crucial to have a well-thought out research plan before any fieldwork is carried out. When developing research questions, from research areas, general questions to specific questions are the hierarchical concepts in the process of developing research questions (Punch, 1998, p.34). Case study methods allow researchers to enter the “subterranean aspects of organizational life” (Ahlstrand, 1990, p.69) and is said to be “the best approach to the analysis of strategy in industrial relations”. Case studies investigate “a contemporary phenomenon within its context, especially when the boundaries between the phenomenon and the context are not clearly evident” (Yin, 2003, p.13).

As this research follows Goldthorpe’s model when he looked at the relationship of car workers to their working environment, it is essential to understand the instruments he had chosen and rationale behind before designing mine. Goldthorpe’s team essentially adopted interviews and field investigations as their main research instruments. They believed these were

suitable methods to study workers' attitudes and behaviour in the context of their industrial employment. They based their study on a smaller number of establishments, the advantage of basing the sample this way enable them to collect fairly detailed information on the conditions of work and work situations of all the individuals concerned. In particular, they wanted to examine the effect on workers' attitudes and behaviour of different types of production system, and their choice of firms was in fact made so that three major types of process productions were represented. After selecting workers in a set of occupational categories, Goldthorpe also set out some basic criteria regarding age, marital status, earnings and residence.

My study traces the working life cycle from when a nurse is recruited, trained, and then at work. It gathers information and evidence which enables the evaluation of the nurses' attitudes towards their work. The case study hospital is a state-owned public-sector Grade 3 Class A listed modern comprehensive hospital under the ultimate control of the Ministry of Health. It is based in the centre of Xi'an, the capital of ShaanXi province, a major economically developed city in Western China with a population of 8.83 million (Xi'an Statistics Bureau, 2017). The hospital has 2,450 employees. The actual methods used are now discussed.

4.6 Document search

Many research techniques could be selected to gather empirical evidence to help understand the research questions. Documents can be divided into primary and secondary sources. Primary sources are those which came into

existence in the period under research. Secondary sources are interpretations of events of that period based on primary sources. Secondary sources are considered as re-analysis of primary documents or survey materials. As Patmore argues, secondary documents are “written after the event and include books, theses, and journal articles” (1988, p.219). There is also a need to take a critical stance on documentary sources. It is common for organisations to show their best side to the public in their published documents. Patmore explains that “documents contain their authors’ interpretations of events and biases” (1988, p.220). Management is unwilling to release sensitive or confidential information, “it is almost impossible for the research to consult all documents of interest because of selective survival and access restrictions” (Patmore, 1998, p.221).

In this case, I have collected a great deal of the hospital’s annual reports, hospital policy documents as well as government documents to support the case study of Chinese state-owned hospital. However, not all documents were available for anyone apart from the hospital’s management board. For example, I asked to see the pay sheets for all surveyed clinical departments’ but the head of HR thought it would breach confidentiality between the hospital and its employees, therefore I was not supplied with those documents. However, through the semi-structured interview conversations I had with the departmental nurses, I was able to get a sense of their wage and the level of bonus pay they earned. Documentary analysis is an easier way to get a general understanding of your research target compared to the other methods.

Numerous authors note qualitative forms of research have gained impetus (Weiner *et al*., 2011; Lasch *et al*., 2010; Pitney and Parker, 2009; Popay *et al*., 1998) and Albert Einstein's assertion that "Not everything that can be counted counts, and not everything that counts can be counted" has been cited to exemplify this (Curry *et al*., 2009. p.1449). With the increasing employment of qualitative methodologies comes a growing awareness that knowledge may vary in origin and form, and that different methodologies are suited to exploring different types of research question (Silverman, 2011).

Before designing the research, I read a large number of government documents on Chinese public-sector hospitals, including changes proposed after the latest Health Care Reform. "Documentation collection will be used often in conjunction with other data", such as interviews (Punch, 1998, p.190). During my initial visit to the hospital, I was able to gather official documentation from the case study hospital, including nurses' professional standards booklet, hospital pay policy for permanent staff, pay policy for fixed-term and temporary workers, and hospital's bonus pay guidelines. Through the help of some friends, I was also able to gather the Shaanxi provincial nurses' recruitment and salary guidelines booklets which are not openly available to the public. These documents have allowed me to gain insights into the policies and related issues around recruitment, reward and retention of nurses in Chinese public-sector hospitals before starting the fieldwork.

4.7 Questionnaires

Quantitative research is usually associated with a number of different approaches to data collection. In sociology, the social survey is one of the main methods of collecting data. The definition of 'social survey' has evolved over the years from a fact-finding study dealing briefly with working-class poverty and with the nature and problems of the community (Wells, 1935) to a more general sense that the terms and the methods associated with it are applied to a vast variety of investigation, including the classical poverty surveys of some sixty years ago to town-planning surveys, market research, and investigations conducted by research institutes, universities and government (Moser and Kalton, 1971). The purpose of social survey is wide – from gathering facts on aspects of public life, or investigating a cause-effect relationship, to adding new aspects of sociological theory. Surveys are interested in studying "the demographic characteristics, the social environment, the activities, or the opinions and attitudes of some group of people" (*ibid,* p.4).

The term 'social survey' is used in a much wider context than that of Well's definition but it by no means covers all types of social investigation. Surveys are used to provide someone with information. Someone here can be a government department, a business, or a research institute, wanting information on a subject matter. Surveys are also used by social scientists as a way to study social conditions, relationships and behaviours. Such as the studies of how different families spend their incomes; how workers react to the latest productivity drive; and the perceived relationship between

education and the possibility of moving up the social ladder. However, it must be noted that the purpose of surveys is not always straightforward. Many studies aim to explain not to describe. Such studies are to test hypothesis suggested by sociological theory, or to evaluate the influence of various factors, which can be shaped by public action, and therefore may be theoretical. The usefulness of surveys in social research is widely debated. Moser and Kalton (1971) suspect social scientists of being excessively keen to use surveys to enable the writing of a report based on the answers collected. Thus the ill-considered launching of surveys has given rise to the skepticism with which some sociologists call ‘door-knocking’ research.

This study faces a very similar challenge in using questionnaire to carry out surveys among Chinese nurses to study their work issues. For example, studies on job stress among Chinese nurses (Zeng, 2009; Yao *et al.*, 2012; Yang *et al.*, 2017) have all indicated two potential limitations - the scale of the study, and the sampling. Data of these researches were collected from a relatively small group of nurses, either from one hospital or from a few hospital within the same province; which means potentially the findings are not representative for other parts of China. Sampling difficulties were mostly down to a lack of staff resources and access, thus complete randomisation was not achievable.

As mentioned above, one type of survey is concerned with people’s opinions and attitudes. Such as the Aly and Shanawany’s study (2016) on the impact of organisational trust on nurses' attitudes towards change in care. This

research adopts survey method as one of the key tools to study nurses' attitudes towards different aspects of their work. The survey's capacity for generating quantifiable data on large numbers of people who are thought to be representative of a wider population in order to test theories or hypotheses has been seen as a means of capturing many of the ingredients of a science (Bryman, 1988).

Surveys can be used to identify the questions such as what, why, how, and where (Naoum 1998). They can also be used to "establish relationship and association between the attributes/objects of the questionnaires" (Naoum, 1998, p.450). Adams and Schvaneveldt (1985) say that the term of survey is used in a variety ways, but a main feature refers to the gathering of data or information from a sample or specific population, usually by questionnaires, interview or telephone survey. I decided to use questionnaire to survey the nurses in the case study hospital to gather more detailed information. The questionnaire had 138 questions covering eight different areas of nurses' attitudes towards their work including attitudes towards others, including patients, co-workers and management, attitudes towards nursing profession, attitudes towards pay and bonus scheme, job evaluation and appraisal, attitudes towards training and personal development, and attitudes towards career development (see appendix A).

Using Likert's scaling style for measurement of attitudes, all the questions begin with 'to what extent do you agree that…', nurses are asked to circle one of the 5 answers which are 1) strongly agree 2) agree 3) don't know 4)

disagree 5) strongly disagree, that best describes their feeling of the questions (Likert, 1932). These twelve clinical departments included the largest, the busiest as well as the smallest teams, measured by the number of in-patient beds, number of nurses working and the amount of overall departmental bonus earned and allocated by the hospital. The data gathered from the questionnaires is processed using computer software (Marklogic Database) which stores all the information entered so that the answers to each question can be analysed. More details of how the data is analysed will be presented in the data collection and analysis part later on. Through the use of questionnaires in this study, I was able to gather a relatively large number of data, providing insights relating to nurses' views of their attitudes towards others, their profession, pay, training and personal development. Whilst this research did not use more sophisticated methods of ordering and measuring 'attitudes' studied in the questionnaires, it did however, present a fairly extensive range of information gathered through the questions asked.

4.8 Semi-structured interviews

Interviews remain one of the most utilised research methods in industrial relations and HRM research. As Whipp notes, "the interview is one of the primary means of accessing the experiences and subjective views of actors, in which detailed, vivid, and inclusive accounts of events and processes may be generated" (1998, p.54). In general, as Bell points out, one major advantage of the interview is its adaptability. Namely, the interviewer can follow up ideas, test responses, and investigate feelings that the questionnaire can never do (2005, p.157). Researchers can achieve more

detailed, in-depth explanations through face to face conversations, and they can also gain a much better understanding of interviewees' perceptions and actions. However, interviews are time-consuming, especially if the participant starts to move into areas that are irrelevant to the study, and may result in valuable time being "wasted" (ibid). In terms of interview types, interview formats vary among structured, semi-structured, and unstructured all of which have their own advantages and disadvantages.

Three major theoretical and epistemological positions on interviews are identified: positivism, emotionalism and constructionism, with each focusing on facts, authentic experiences and the construction of interview responses (Alvesson, 2010). A traditional yet still dominating position taken to interviewing is neo-positivism. Guidelines for a good interview involve issues such as:

> "Not becoming involved in explanations of the study, being brief and using a standardized presentation. Not deviating from the structure of the interview. Being neutral and avoiding getting personal." (Alvesson, 2010, p.18).

Few would doubt that the interviewer effect or other contingencies influence the outcome, but the neo-positivists believe these are minimalized. In this case, "the interview conversation is a pipeline for transmitting knowledge" (Holstein and Gubrium, 1997, p.113), and interview questions "are intended to tap individual experience" (Charmaz, 2003, p.315). Sensitivity and

judgement are thought to be necessary and interviews should not be conducted mechanically.

In contrast, romanticism means that the nearer we get to the respondent, the closer we are to apprehend the real self. It is through this closeness and depth we find the authentic and true, which are often expressed in our talk (Dingwall, 1997). Romanticism is also referred to as 'emotionalism', where the data is about authentic subjective experiences that are shared through unstructured, open-ended interviews (Silverman, 2006). A romantic researcher believes in establishing a rapport, trust and commitment between interviewer and interviewee, and as a result the interview is turned into a 'warm' situation. In a warm situation the interviewee is free to express themselves authentically and will deliver open and trustworthy talk (Alvesson, 2010).

Structured interviews enable the interviewer to control the content of the interview so that consistency can be maintained, but this approach tends to be formal, rigid question and answer session. The unstructured interview may be useful at the early stage of a research process, but it can be very difficult to control. So a semi-structured interview is often favoured by researchers. It is more of a conversation, which in turn may relax the participant and produce better results. There is always the danger of bias creeping into interviews, largely because, as Sellitiz *et al*. (1962, p.583) point out, "interviewers are human beings and not machines, and their manner may have an effect on respondents".

In the field of ethnography interviews have been criticised for their limitations, which primarily relate to the interviewee as an imperfect informant (Douglas, 1976; Walford, 2009; Roulston, 2010). Douglas (1976) notes that interviewees may have incomplete knowledge or faulty memory on a given subject, or may misdirect, evade, lie or front in interviews. This is clearly a problem, particularly for studies concerned with looking at cultural aspects of the social world, where a number of cultural meanings and values are hidden behind implicit assumptions (Hall, 1959) and cannot be accessed by interview alone. However, this study was not concerned with a wider social phenomenon. Indeed this thesis sought to explore individuals' accounts of their experiences and understandings, and as such the semi-structured interview was an appropriate way of gathering this information.

4.9 Data collection and data analysis

Unlike experimental studies that often employ a range of different measures and instrumentation, in qualitative studies the researcher is the instrument of data collection and analysis (Patton, 2002). The closeness of the researcher to the research participants, and the impact this may have on the research findings has been the subject of much discussion (Richards and Emslie, 2000; Chiovitti and Piran, 2003; Norlyk and Harder, 2010; Hamil and Sinclair, 2010; Day, 2012). The concern being that the researcher is capable of bringing in their own personal preconceptions to the interview and analysis, and thus is capable of influencing the interview direction, interviewee responses and the interpretation and presentation of the research findings. Most qualitative approaches consider addressing this issue as important for

producing work, which is both rigorous and credible, however, how this potential for 'bias' is addressed varies.

From a traditional, scientific standpoint, undue influence over the interview process is to be avoided, as approaches informed by this rationale seek to provide a "mirror reflection" of the subject investigated (Miller and Glassner, 2004, p.125). Therefore, the researcher should remain neutral and distant from the research subject, minimising the display of personal value or feeling during the interview, an outsider looking into the participant's world (Hamil and Sinclair, 2010). One method of minimising researcher bias needs the individual investigator to first identify their own underlying preconceptions and assumptions, and then to leave them outside the interview (Cutcliffe and McKenna, 1999; Hamil and Sinclair, 2010; Overgaard, 2010). As Overgaard (2010, p.322) explains:

> "by putting all our knowledge and beliefs about the world on "standby"—all the knowledge that, as it were, sees straight through our world-experience, taking it for granted—we are in a position to achieve an undistorted view of world-experience as such".

This is known as bracketing, a concept attributed to Husserl (1964, in Cutcliffe and McKenna 1999) the founder of phenomenology and is a method adopted in a number of published studies (Mulhall, 2002; Ek and Ternestedt, 2008). But as an activity, bracketing requires the researcher to be conscious of their own preconceptions, and as some preconceptions may be subconscious, researcher bias may still occur (Onwuegbuzie, 2003).

Bracketing has been questioned both in phenomenological circles and elsewhere, with some contending that it is not possible for the researcher to fully remove their values and influence from the research process (Maggs-Rapport, 2001; de Witt and Ploeg, 2006). This argument is driven by the belief that preconceptions are inherent, culturally embedded components, which cannot be fully identified and extracted from the research process (Devers, 1999).

Instead of attempting to bracket, adopting a reflexive approach is advocated, in order to make influential factors as transparent as possible (Johnson and Waterfield, 2004; Finlay, 2006). I recognise the inextricable nature of the researcher's values, and the need for acknowledgement of these (Lowes and Prowse, 2001). Like bracketing, this entails the researcher considering their own experiences and preconceptions surrounding the subject area. However, these are not removed from the scenario and are instead minimised where possible and made explicit throughout (Shaw, 2010). It is argued that this enables the reader to judge the researcher's influence and enhances the credibility of the work (Johnson and Waterfield, 2004).

Whilst reflexivity can provide credibility to qualitative work when employed sensitively, it can also be used as a mask to "persuade the reader of credibility with little explanation or evidence of true engagement" (Ballinger, 2006, p.236). Engagement is an important feature of reflexivity, which does not end with the researcher making their underlying beliefs and presumptions known. Instead, it is a continuous and documented process of reflection and

self-questioning on the part of the researcher, which should span the research process from the inception of the research question(s), to the dissemination of the study findings (Johnson and Waterfield, 2004; Ballinger, 2006).

All the questionnaires of this study were brought back to the UK. Data collected were manually put in excel sheets. Given this was not a statistical study, rather a social one, no specific data measurement tools or software were used. The purpose of this study is to use questionnaire to survey how the nurses feel about their work issues and their work terms and conditions. So a simple analysis of how the nurses answered to the questions would suffice. Based on this, an open source analysing tool developed by Marklogic was chosen because it could display each answer to each question, the number of respondents under each answer, and the relevant percentage of that group.

Thematic analysis is recognised as a versatile approach, which is not tied to a particular set of epistemological assumptions (Braun and Clarke, 2006; Floersch *et al.*, 2010) and provides a clear, systematic way to approach the data. This method is appropriate when the research aims to uncover “the meanings produced by and in people, situations, and events” (Floersch *et al*., 2010, p.408) and was the method of analysis employed in this thesis. Thematic analysis involves searching for and identifying patterns of meaning within a given data set (Joffe and Yardley, 2003).

4.10 The fieldwork

Shortly after starting to design and plan my research fieldwork, I flew back to China and met up with my contact at the case study hospital to discuss the help I needed. I conducted my MA fieldwork in the same hospital and had built a good rapport and trust with many of the hospitals' senior members of staff and numerous nurses who I had spoken to in the past formally and unofficially about their work. I had kept in contact and had since then spoken to many nurses about some of the issues that troubled them.

Chinese organisations do not usually open their doors to scientific academic studies. The head of the hospital and many doctors working there had studied abroad before, mainly in the US, so there was an understanding and appreciation that all that I was trying to achieve was conducting an academic research though various levels of approval were sought in the hospital before the research was able to begin. I was asked to submit the questionnaire along with the semi-structured interview questions to the Head Nurse months before I intended to go back for the actual fieldwork. I was also asked to write a 'letter of guarantee' stating that data and documentations collected were strictly for the use of my research only. I had to wait for a couple of months after having submitted the research proposal before gaining permission.

I went back to Xi'an in March, 2011 to carry out the fieldwork. I spent about three weeks in Xi'an during which I handed out the questionnaires, did the interviews and collected the questionnaires. Questionnaires were handed out to 330 nurses working in twelve different clinical departments. These twelve

clinical departments included the largest, the busiest as well as the smallest teams, measured by the number of in-patient beds, number of nurses working and the amount of overall departmental bonus earned and allocated by the hospital.

I had communicated with the head nurse who helped identify these twelve clinical departments before the research and asked for such arrangements to be made so that I could in theory gain an unbiased and balanced group of nurses' knowledge towards their work. I was accompanied by the Head Nurse when delivering the questionnaires to these twelve teams. When handing out the questionnaires, I repeatedly explained to the nurses that the questionnaire was anonymous and that this was my academic study, everything shared with me would not be shown to hospital management and strict confidentiality will be guaranteed. But not all nurses understood the term academic research so I also referred them to the explicit word written on the first page of the questionnaire that "All information given in this questionnaire is confidential and for my study only, information will be not shared with the hospital or anyone else."

Even though this had been made clear right from the start, I did fear some of the surveyed nurses were still reluctant on some of the sensitive questions asked. This concern is shared by Shaffir and Sebbins who point out that "the problem of validity in field research concerns and difficulty of gaining an accurate or true impression of the phenomenon under study" (1991, p.12). I had given nurses a week to fill out the questionnaires and I had told them

that I would personally come back to collect them. When I went back to collect the questionnaires, not all of them were ready and I had to call back on different occasions waited or went back after a couple of days to pick them up. This had been an exhausting experience as nurses did shift work and I had to keep going back to different wards to wait for the questionnaires to be ready. This happened to all the wards I was collecting the questionnaires from.

I conducted fifteen semi-structured interviews for this study. All interviews were recorded and later transcribed and translated from Chinese into English by myself. Nearly all interviews with the departmental head nurses were done in a quiet on-call room located in busy hospital wards. Days before the interviews, I was accompanied by the hospital head nurse to meet with every single departmental head nurse to arrange a time that suited them. Every nurse I met I made sure it was clear that they were aware I am a PhD student trying to carry out a piece of academic research and confidentiality is guaranteed, meaning nothing they say to me would be shared with the hospital. I also explained to these nurses that the head nurse was only there to introduce us, but she would not be attending the actual interviews with me. I made this point because I did not want the nurses to think I had a good and personal friendship with the head nurse, as “impartiality is important otherwise difficulties may arise” with employees being aware of associations with management (Kitay and Callus, 1998, p.109). I spent nearly two weeks conducting these interviews.

All the head nurses had a very busy and sometimes manic schedule. They mostly worked Monday to Friday with no shift work requirement. During each of their working day, they have to carry out management duties as well as stepping in to help cover for sicknesses and absences. So on a few occasions, I had to wait a few hours past our scheduled interview time before the head nurse was able to talk to me. During the actual interviews, there was always just the interviewee and myself. At the beginning of every interview, I always began by saying “This research is for my PhD dissertation, all information will be treated anonymously and confidentially, no information will be shared with anyone from the hospital under any circumstance”. I then went on to ask for permission to record the interviews – again, I had to explain the reason why I was recording them was “to make sure I have the full interview which I can listen back to when writing it up”, all nurses agreed to be recorded. On a number of occasions while the interview was in progress, colleagues of the departmental head nurses, knocked on the door and interrupted the interviews because they needed approval of something or wanted the head nurse to turn to an immediate issue. As such times, recordings were paused and later re-started. The recordings have proven to be highly valuable when I was analysing the information as they “provide a more accurate rendition than any other method” (Yin, 2003, p.92).

Some argue that interviews can be very subjective or even biased because “interviewees are human beings, so the researcher needs to be wise, vigilant and critical of interpretation of the date (Bell 2005, p.167). I had learned through my MA studies that bonus pay at the case study hospital was a

highly controversial subject depending on who you speak to. In my research this time, the head of hospital and the hospital Head nurse both acknowledged this issue, however the head of HR used a more 'official tone' when explaining the hospital's bonus scheme and told me people felt motivated by the scheme and that they were happy and satisfied about the bonus pay.

One of the main issues around case study is "the prevention of bias generated from interviews" (Saunders *et al*., 2007, p.318). I prepared myself before the interviews to avoid possible prejudice, by studying the performance of each surveyed clinical departments the nurses belong to, the profiles of the interviewees and a large amount of documents about the hospital. My understanding of a nurse's daily tasks and how their work was determined and managed began to build up as well as how the latest health reform in China affects the daily running of a public sector hospital. The information I acquired during the preparation stage had assisted me to understand and pick up the interviewees' attitudes and opinions on different matters during the interviews.

In this research, I had used a large number of documents as supporting evidence and background information. I see these documents as a primary source because they are "those which came into existence in the period under research" (Bell, 2005, p.125). Collecting these documents was not always easy. Official government documents are seen as 'sensitive' material in a public sector organisation employees were often told what the document

had said in a less formal format which basically means hardly anyone had or had seen a copy of the actual document of a particular policy. This meant getting hold of any particular document is extremely difficult because most people did not even know where to start to look for them. However, the difficulty of getting hold of some hospital documents proved to be even more severe. For example, I wanted a detailed policy on bonus payment for each clinical department and service department, the head of HR told me he could not share this document with me unless it was pre-agreed by the head of hospital. This however did not stop me from gathering enough information and evidence for the research. This kind of attitude is widely seen in China because people do not want to take any responsibility should anything ever go wrong. I understand that employees in the hospital worried that I might disclose their sensitive pay documents.

In addition to the documents I received from the case study hospital, my contact in the Ministry of Health helped me to get hold of some important government documents regarding the latest health reform. I had also relied on the Internet on some of the latest, constant changing government policies regarding the health reform. I have gained access to most of the major Industrial Relations and Human Resource Management electronic journals through the Wolverhampton University's online E-journal service, which allows me to read and use academic journals as references.

Both the interview recording data and the questionnaire data were extremely time-consuming to process. It is said that "the task of transcribing audio-

recorded interview is likely to be time consuming" and researchers "must also remember to ensure it can be linked to the contextual information that locates the interview" (Saunders *et al*., 2007, p.475). All interviews were conducted in Chinese, I had to transcribe and translate everything into English. Bamber *et al.* points out that one of the challenges of doing a comparative study is that "the lack of a common language and terminology may create confusion" (2004, p.6). The questionnaires were in Chinese too. When doing the translation for questionnaire and interviews, it "requires care if your translated or target questionnaire is to be decoded and answered by respondents in the way you intended" (Saunders *et al.,* 2003, p.375). When doing a cross culture international research, Saunders *et al.* (2003, p.377) believes it is crucial to ensure the translation has the "same meaning to all respondents".

4.11 Bias, validity, reliability and ethics

Reliability and validity can be treated as two limitations of research fieldwork. These do affect our proposed research: during planning and conducting our research, we have to ensure the results are reliable and valid, and avoid bias. Kitay and Callus (1998, p.111) point out, "it does not necessarily mean that each interview or observation must be replicated at each site, but the issues studied must be the same and the information must be comparable". Bell (2005, p.117) clarifies that "reliability is the extent to which a test or procedure produces similar results under constant conditions on all occasions". Through careful design of research methods, researchers can reduce ambiguities. Bell brings out a number of devices for checking

reliability, such as “test-retest”, “alternate forms method” and “split-half method”. However she also notes that these methods are not always “feasible or necessary” *(ibid*). Compared with reliability, validity is a more problematic concept being concerned with the extent to which the evidence is a true picture of what is being studied. Take further steps, an unreliable material can lead to a result lacking of validity. Even if a reliable term, it can also result in invalidity in research. According to Sapsford and Jupp, validity is described as the “design of research to provide credible conclusion; whether the evidence which the research offers can bear the weight of the interpretation that is put on in” (1996, p.1). An item which has been measured or described should conform to what expected. The degree of reliability and validity is restricted by limited access, for an instance, employees picked by management that are sent to be interviewed.

Ethical behaviour helps protect individuals, communities and environments, and offer the potential to increase the sum of good in the world. Social scientists do not have a given right to conduct research involving other people. The reason why social scientists continue to be able to conduct such work is down to individual and social goodwill and in turn depends on scientists acting in ways that are not harmful, and this ethical behaviour helps assure the climate of trust (Israel, 2014). By caring about ethics and by activing responsibly, integrity of research is promoted.

For this research, I carried out twelve interviews with the head nurses from the twelve surveyed clinical departments; one interview with the head of

hospital; one interview with the head of HR, and one interview with the hospital head nurse. I was able to record all of the interviews. Some of the departmental head nurses initially had concerns and asked if we could do the interviews off the record. I explained that the research is for academic purpose only and no personal information would be revealed and that I will not share the recording with anyone from the hospital. In the end, all head nurses were happy for me to record the conversation.

Unfortunately, due to constrains and the limited resources of the study, I was unable to effectively pilot the questions in the survey. However, I did discuss the questions with a few nurses and nurse managers during the designing stage. In addition, a few years prior to this study, I carried out my Master's degree research at the case study hospital looking at Chinese nurses' pay, and that experience gave me some confidence in the questions set out in this study.

The head nurse helped to choose the twelve clinical departments to be surveyed after I explained to her my requirements – I wanted to survey about 300 nurses in the hospital from at least ten clinical departments; I made it clear that we could not choose and select nurses to survey from each department, it had to be all nurses from each department; the chosen departments had to have nurses on both continuing and fixed term contracts. In designing the survey, the question of whether to ask participants' personal data, such as gender and age, was carefully considered. It was decided that such information could risk participants being easily identified, and therefore

unethical to be included. As an example, the case study hospital only had two male nurses at the time, that by asking for participants' gender, it would not provide stronger evidence but subsequently expose participants' identity. Another consideration was that since the questionnaire was anonymous, if participant's gender and age were collected, it could potentially make them feel less open to speak their mind in case of being identified. The head nurse satisfied my research requirements and chose twelve clinical departments that had a total number of 330 nurses. 330 questionnaires were handed out to all the nurses working in these twelve clinical departments and 300 valid questionnaires were collected (90%), of which thirty were discounted due to incomplete filling, inconsistencies, logical concerns, or missing information.

I personally sent the questionnaires out to all the departments and the head of each department has made sure that all nurses on different shifts were aware of the research. I went back after to each department between one to two weeks after the questionnaires were handed out to collect the finished questionnaires myself and met some of the nurses who took part. They were very friendly to me as I had established a good rapport with the nurses working there when doing my MA research in the hospital. The response rate for this research was 90% which is very high. I believe this was due to the good relationship I had formed with some of the nurses during my previous research as well as during the planning stages of this research when I went and spoke to them to find out about their everyday tasks. They were very supportive of this research so they were willing to use their precious break or spare time to help with the research. The questionnaire

findings showed a high level of ‘don’t know’ responses to some survey questions, this is known as the missing value problem (Roderick and Donald, 1989; Sterne et al., 2009). Non-response/don’t know responses usually occur when questions are poorly worded, so as a result respondents simply do not know the answers; or that the questions are two sensitive so respondents do not want to answer. This raised a validity question because high don’t know responses make answers less valid but these answers were treated with caution in the analysis.

4.12 Conclusion

The strengths and weaknesses of research methods were analysed. During any research, one must avoid common mistakes and obtain meaningful data. There is no perfect research method that can be adopted, but one needs to try to improve reliability and validity as much as possible. Researchers ought to use the right research method that is the most suited to the research and avoid using mechanism that is inappropriate. This chapter offered an opportunity to closely examine the case study approach, documentation, questionnaire, and interview methods deployed in this research. It also looked at the details of how the interviews were conducted, recorded, transcribed and analysed. Questionnaires were used as a main tool to gather data which showed how the nurses felt about their own work; and this section also looked at how the questionnaires were delivered and collected and discussed the validity of the data.

This study has tried overcome potential ethnographic problems to ensure reliability and validity of the data, but despite of limitations, such as timing, financial constraint and translation challenges, it shares some similar limitations with other studies on Chinese nurses. Firstly, the limited scale of the questionnaire data, the study was carried out in one top-class public hospital in a big city. Not all nurses in the case study hospital took part in the survey, which means potentially the findings are not representative for other parts of China. But as part of a PhD project, the field work of this research has always tried to meet the highest possible standards in regard to reliability and validity. As such, the upcoming chapters will analyse the data and examine how different relationships between nurses and their co-workers, their managers, their patients might affect their attitudes towards their work.

Chapter Five

Chinese nurses' working lives

5.1 Introduction

This chapter focuses on testing the following two hypotheses set out at the beginning of this study as some of the main relevant factors of nurses' attitudes to and at work: the nature of Chinese public sector hospital nurses' work relations, including their relations with patients, co-workers and management; and the nature of the profession, how nurses feel towards nursing profession. The questionnaire findings of the case study hospital nurses along with the interview findings of hospital management will be presented.

The chapter begins by reinforcing the literature on labour process and the division of labour within nursing (Bach *et al.*, 2012; Lloyd and Seifert 1995). The relationship between job autonomy and professionalism is discussed, and a debate of the growing tension between qualified permanent nurses and lower-status nurses are analysed. This is followed by some findings of nurses' attitudes towards patients, co-workers, and management.

The second part of this chapter discusses Chinese nurses' attitudes towards the nursing profession. In China, nurses are often described as "White Angles" for their generous contribution to public health (Liu *et al*., 2004), but for those in the nursing profession, nurses' image has always been a concern. Through the findings of this study, issues around job stress, job

satisfaction and the lack of recognition both from the employer and the society will be looked at, and importantly, how these elements of nurses' working lives affect their attitudes to their work.

Finally, the chapter ends on a discussion of how nurses' attitudes towards others and the profession affect nurses' job satisfaction, causing high nursing turnover rates and long-term nurse shortage.

5.2 Labour process and professional issues

As discussed in the literature chapter, labour process analysis is "used by management studies to formulate more effective strategies of control through acknowledgement and incorporation of labour's subjectivity" (Tinel, 2009, p.12). Early labour process in the capitalist way of production means workers derived power from their strategic location in the labour process, because the traditional mode of production was controlled by workers' knowledge and their craft skills (Braverman, 1974). This created the power struggle between employees and employers, and employees used this dynamic to maximise their positional power, while employers wanted to reduce employee power by changing control structures and job design (Wallace *et al.*, 1989). Changing control structures and job design is done based on the principles that the labour process is detached from the skills of the workers, execution is largely separated from conception, and management controlling each step of the labour process and the way work is carried out.

This is known as the division of labour. It is believed that when the division of labour increases, labour is simplified (Marx, 1849). The division of labour enables employers to break down and simplify tasks so they can choose the exact skills needed for a job, but it decreases workers' specialisation in any set of skills (Cohen, 1988). The purpose of the division of labour is to maximise productivity and minimise labour costs, but by achieving this employers reduce the job autonomy of professional work in order to gain more managerial control. Job autonomy, however, is an important element of professionalism (Engel, 1970; Lee, 1998; Curtis and Glacken, 2014) with professionals controlling their own work (Freidson, 1994), and should be able and capable of making independent decisions (Scott, 1998).

With regard to the debate of the division of labour in nursing, there has been a major shift from solely focusing on the boundaries between the work of nurses and doctors to the potential for divisions within nursing (Bach *et a*l., 2012). It has been acknowledged that shifting occupation boundaries may lead to lower paid healthcare workers. The spread of managerialism in hospitals increased the pressure on the workforce and reinforced the divisions between nurses and those with management authority (Bach, 2004; Cooke, 2006, 2012). Divisions within nursing vary by specialism too. This is demonstrated in Bolton's work (2005) where gynaecology nurse were found to use humour to reaffirm the meaning of their work and show their distinctiveness. Nurses may feel the need to emphasise the distinctive contribution in relation to other specialities within nursing, as well as comparing to other medical professions. Within the nursing hierarchy, nurses

want to separate themselves from jobs that are lower down the chain (Allen, 2001). Some argue the potential in this process for up-skilling nurses (Ackroyd, 1998), but in reality, the decision in the UK public sector to use an increasing number of the cheaper 'assistant' roles established in health and social care has made a big change of division of labour within nursing (Bach *et al*., 2006).

In 2012, there were between 106,500 to 270 000 HCAs in the UK providing supportive tasks to doctors and nurses (Health and Social Care Information Centre, 2012; Cavendish, 2013: 6, 15). Assistants in these posts were almost satisfied with their jobs and believed there were career opportunities for them to either develop in their existing roles or to move into a more skilled role (Bach *et al.*, 2007). The lack of a consistent definition of the health care assistant role has not stopped the role from either existing or developing (Kessler *et al*., 2013). As a result, HCAs have gradually taken the place of nursing assistants and nursing auxiliary. This has created tension between nurses and HCAs. Daykin and Clarke (2000) reported a small decline in the ratio of qualified nurses to HCAs. The argument is that the delegation of tasks to HCAs threatened nurses' professionalisation strategy, which blurred the separation of basic care tasks from more technical duties. Thus creating the different perspectives on the appropriate role and contribution of HCAs (Thornley, 2003; Spilsbury and Meyer, 2004; Keeney *et al*., 2005).

Thornley (1996) discussed the two features of the traditional model of nursing workforce development: less qualified nursing auxiliaries, later

named HCAs, used as substitutes for registered nurses; and the boundaries between registered nurses and HCAs becoming less clear. The government supported the expansion of non-registered nursing workforce to relieve nursing shortage caused by poor working conditions. The Royal College of Nursing (RCN) has attempted to define the distinctive contribution of the registered nurse:

> "Not all nursing is undertaken by qualified nurses ... other people who 'do nursing' include ... a variety of care assistants and support workers. Their contribution to care is invaluable, but it is different from that of the professional nurse" (RCN, 2004, p. 3).

With the focus on HCAs delivering most of the hands-on care, compared with registered nurses' holistic patient-centred approach, the nurses want to establish a clear boundary with HCAs (Bach *et al,* 2012), and disputes between the two occupations are more common than had been anticipated (Daykin and Clarke, 2000).

New job boundaries and workers' task allocation decisions are intertwined with the debates about 'eligibility rules', who may be employed, how many, training requirements, and performance management. The new nursing ideology thus far has shifted from one nurses performing the same allocated tasks on different patients repeated through a working day, to a nurse providing all care needed by the patient (Allen, 2001). The debate between nursing roles and doctors have shifted to a debate within nursing, and nurses seek to stress their unique contribution not only in relation to medical

personnel but also comparing to other nurse specialties They also seek to separate themselves from those in lower status roles among the nursing hierarchical structure. The approach of this case study is based on Goldthorpe's model when he looked at the relationship of car workers to their working lives. In particular he sought to both describe the total set of relationships as well as to explain the emergence of instrumentality. As he explains, "The primary aim of this monograph is descriptive: to give some account of the attitudes and behaviour of a sample of 'affluent' manual workers in the context of their industrial employment." (1968, p.1)

5.3 Nurses' attitudes towards others

A large part of nurses' daily work involves interacting with different groups of people, including other nurses or co-workers, patients, doctors, nurse managers, physicians, pharmacists, cleaners, and patients' relatives. Many of the interactions between nurses and doctors, and nurses and nurse managers usually mean nurses taking orders from doctors or nurse managers, whilst not having much autonomy in what to do and how it is done. Nurses' job autonomy at work, as discussed in the literature chapter, is an important element for nurses, and autonomy of practice is a key contributor to nurses' job satisfaction (Aiken *et al.*, 2002; Thompson, 2012). In this chapter, findings of the nurses' attitudes towards patients, co-workers and management are discussed. How these relationships affect nurses' job autonomy and job satisfaction are analysed.

5.3.1 Nurses' attitudes towards patients

Many argue that patients' satisfaction with nursing care generally depends on the degree of convergence between their expectations of ideal care and their perception of the care they really receive (Chen *et al.,* 2012; Wang *et al.*, 2017). The MOH has increasingly emphasised the importance of providing high quality health care with a focus on patient-centred care (Huang *et al.*, 2012). The head of the researched hospital gave an example of what 'providing high quality health care' means for their nurses:

> "Under the government's requirement for 'High Quality Care', tasks like washing patients' feet, hair, face and cutting patients' fingernails and toenails all fall on nurses. But actually in many countries aboard, these tasks are not carried out by nurses but by care workers, however in our country, these tasks are given to nurses."

The head of the hospital went on to explain what impact 'High Quality Care' scheme had on staffing:

> "So in our hospital, we are implementing the 'High Quality Care' scheme, but we haven't met the government's standard of nurse-to-bed ratio for the scheme. Last year, when I was trying to implement this scheme, I did a quick calculation - the result showed that I had to recruit over one hundred nurses and another one hundred care workers in order to meet the scheme's standard nurse-to-bed ratio. If I were to increase the number of staff, the cost increases at the same time, but the hospital's charges are not allowed to go up. So these extra services we provide seem pointless – the hospital's earnings

> does not go up but cost and spending do, so how would you run this hospital? That is the crux of the problem. Having said all that, despite the difficulty, we are trying to meet the government's requirements."

This suggests, as discussed in the previous chapter, that requirements and expectations set by the government along with the patients' demands are not always reasonable, and it may interfere with nursing care content, and quality improvement is difficult to achieve (Wang *et al.*, 2017). The MOH stated that as part of the High Quality Care project, nurses should monitor the patients' condition, drug administration and therapy, and communicate health recommendations to the assigned patients (MOH, 2010).

The question "Do you agree that you have enough time to look after every patient?" revealed the vast majority of respondents did not have enough time to look after every patient. Fifty-two (16%) strongly disagreed; 120 (36%) disagreed; forty-eight (15%) said they did not know; only seventy-four (23%) said they had enough time to look after every patient. This means over half of nurses did not feel they had enough time to carry out their tasks which raises major concern for the quality of patient care. This also suggests the current number of nurses in China represented a nurse-to-population ratio of 1.66 nurses per 1000 people, compared with a global average of 5.06 nurses per 1000 (MOH, 2012) is associated with poorer nurse outcomes, as found in many previous studies (You *et al.*, 2013; Zhang *et al.*, 2014;).

Table 5.1 Attitudes towards patients

To what extent do you agree that…

No	Question	Attitudes towards patients					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	you have a good harmonious relationship with your patients.	23% (76)	56% (186)	8% (27)	2% (6)	0.6% (2)	10% (33)
2	you are always very enthusiastic to help patients.	32% (105)	51% (169)	6% (19)	0.9% (3)	0% (0)	10% (34)
3	you feel sympathetic towards patients.	34% (113)	51% (168)	4% (14)	0.6% (2)	0% (0)	10% (33)
4	you are polite towards patients.	36% (119)	50% (164)	4% (13)	0% (0)	0% (0)	10% (34)
5	you answer all patients' questions politely.	32% (107)	49% (160)	8% (26)	0.9% (3)	0.3% (1)	10% (33)
6	you sometimes chat with the patients.	28% (93)	50% (166)	8% (25)	4% (12)	0% (0)	10% (34)
7	patients recognise your hard work.	18% (58)	36% (120)	24% (78)	9% (29)	3% (11)	10% (34)
8	your work is very important to patients' recovery process.	34% (112)	45% (147)	11% (35)	0.6% (2)	0% (0)	10% (34)
9	patients rely on you to look after them.	16% (54)	44% (144)	24% (80)	6% (18)	0.3% (1)	10% (33)
10	you feel respected by the patients.	14% (46)	37% (123)	21% (68)	13% (42)	5% (16)	11% (35)
11	patients are cooperative when you are doing your work.	17% (55)	53% (174)	11% (37)	7% (22)	2% (8)	10% (34)
12	patients have lots of requests.	26% (87)	48% (158)	7% (22)	9% (28)	0.3% (1)	10% (34)
13	patients can be very rude.	32% (105)	43% (141)	8% (25)	7% (24)	0.6% (2)	10% (33)
14	you have enough time to look after every patient.	4% (12)	19% (62)	15% (48)	36% (120)	16% (52)	11% (36)
15	patients' family members give you presents in exchange for better care of their family.	2% (8)	13% (42)	16% (54)	37% (121)	21% (70)	11% (35)
16	you know the different needs different patients have.	8% (26)	44% (146)	23% (77)	12% (39)	2% (8)	10% (34)
17	you have too many patients to look after.	21% (68)	49% (160)	10% (33)	9% (29)	2% (7)	10% (33)
18	**you can choose which patients you look after.**	**2% (7)**	**9% (31)**	**11% (37)**	**39% (128)**	**29% (94)**	**10% (33)**

The promotion and requirement of nurses providing holistic care to patients should be supported by an effective system of guidelines that clearly allocate responsibilities and work flow, with the total number of nurses not being less than half of the total health workforce in the hospital, and the nurse-to-bed ratio should be at least 0.4–1. The head nurse of the case study hospital clearly stated that their hospital has not met the nurse-to-bed ratio, “We are implementing the ‘High Quality Care’ scheme, but we haven’t met the government’s standard of nurse-to-bed ratio for the scheme”. It is no wonder why nurses did not feel they have enough time to attend to every patient. The situation seemed to be worsened by the large amount of patients’ requests (Q12, Table 5.1) – 296 (90%) answered this question; of those, eighty-seven (26%) strongly agreed that patients had a lot of requests; 158 (48%) agreed; twenty-two (7%) said they did not know; twenty-eight (9%) disagreed and only 1 (0.3%) strongly disagreed. Further to this questions, respondents were also asked if they agreed patients can be very rude (Q13, Table 5.1) – 297 (90%) answered this question; of those, 246 (75%) agreed; only twenty-five (8%) said they did not think so.

Under the new patient-centred care scheme, patients are given more rights than ever before, but it had not always been the case.The influences of traditional Chinese culture means doctors and medical staff always had higher social status than patients. The head of the hospital explained how the government medical workers are slowly changing this concept:

> “In China, doctors have a very high social status. In old China, we say ‘Qiu Yi’ - beg for medical treatment, you do not have any dignity if you

beg me to treat you. People in those days believe doctors have dignity, patients do not. So what we are trying to do now is to change this view. How do we change it? Some big name doctors would not treat those patients who do not treat them well or appear to be arrogant. It is hard to change this concept. Over the years, we have been trying to changing our attitude towards patients; we are improving our service quality which so far is proving to be effective. So we are changing the old concept slowly. Patients' rights are not fully exercised in China but it takes more than twenty-four hours to change this. We have to take this step by step, through changing the policy and improving education."

Despite over half (60%) of the respondents answered positively towards the question if patients rely on nurses to look after them (Q9, Table 5.1); only 178 (54%) respondents felt that the patients recognised their hard work (Q7, Table 5.1), and 169 (51%) respondents said they felt respected by the patients (Q10, Table 5.1). This suggests higher patient-to-nurse ratio is not only associated with poorer nurse job satisfactions, but also poorer or fair quality of care. Departmental head nurse 1 associated lower quality patient care with the general nurse shortage:

"Overall, there's a shortage for nurses, not enough nurses to cover the massive workload. Especially for some of the wards, there are so many patients; we have to add extra beds in the wards, so nurses will have to take on extra work. Another thing is that these days, patients are subscribed a lot of drugs, unlike before, patients don't have as

> many injections or drips, so now nurses have to spend much more time on treatments than before. As a result, the nursing care side of things are not done properly."

Caring is regarded as an elusive concept that defies definition due to its complexity and diversity (Chipman, 1991; Komorita et al., 1991; Morrison, 1991; Morse *et al.*, 1991.) During this research, many nurses indicated that they had to spend a huge amount of their working hours performing the medical orders of the doctors, departmental head nurse 1 revealed a reason for increasing workload when I asked if she thought the hospital's bonus scheme caused any problem among the workers and she said "…Our workload has increased a lot due to the number of medications that are subscribed…."

This is indicative that the government's current pay system which categories hospitals as 'fully-state-funded', 'semi-funded', and 'self-funded' units, have raised questions as to if this model really works, especially when stated owned 'semi-funded' hospitals are encouraged to generate income so staff salary and bonus are paid. In this instance, hospitals receive more revenue through oversubscription of medication; doctors receive commission from pharmaceutical companies; patients are in hospitals for longer receiving unnecessary treatments; hospital beds become scarce; nurses are overworked carrying out doctors' orders and looking after extra patients. This creates a reoccurring vicious circle which only the hospitals can stop by changing how employees' pay is determined.

Helping with the emotional needs of patients is not seen as part of nursing work in China, because Chinese nurses focus on tasks-orientated nursing practice, so 'getting the work done' instead of talking with patients is the norm (Melia, 1987). Even though the findings showed that only half of the nurses felt respected by their patients (Q10, Table 5.1), the vast majority of respondents (79%) thought they had a good, harmonious relationship with their patients (Q1, Table 5.1), and that they (83%) were always very enthusiastic to help patients (Q2, Table 5.1). Based on the findings of this research, 52% respondents said they did not have enough time to look after each patient (Q14, Table 5.1), it is a little surprising to find 259 (78%) respondents indicated that they sometimes chatted with their patients (Q 1, Table 5.1); furthermore, 267 (81%) respondents said they answered all of the patients' questions politely (Q4, Table 5.1), and nearly all, 296 (90%), respondents felt they were polite towards patients (Q3, Table 5.1). This suggests that nurses in this study generally believed they had a good relationship with their patients, which is in line with a recent study looking at tensions between medical professional and patients in mainland China (Zhang and Sleeboom-Faulkner, 2011).

5.3.2 Nurses' attitudes towards co-workers

As discussed in the earlier chapters, Chinese nurses strive to keep a harmonious relationship at workplaces with their co-workers. These behavioral principles are directed by Confucianism, which emphasises the value of harmony, asking individuals to accustom to collectivity, to control one's emotions, to avoid conflict, and to maintain inner harmony (Kirkbride

and Tang, 1992). This is backed up by the findings – 297 (90%) participants responded when asked if they have a harmonious working relationship with their colleagues (Q4, Table 5.2). Of those, 261 (79%) agreed that they had a harmonious working relationship with their colleagues. They were also asked if everyone has a good working relationship within the team (Q6, Table 5.2). 296 (90%) answers this question, 239 (72%) agreed that everyone in their team had a good working relationship; only thirteen (4%) disagreed with this statement. Whether harmony between team members exist was further tested by asking the respondents to indicate if they have many disagreements/conflicts and misunderstandings with their colleagues (Q9, Table 5.1). Of those (90%) answered, only nine (11%) said they had many disagreements, 230 (70%) disagreed with the statement.

The questionnaire also asked if their colleagues give them special support and help if they encountered difficulties at work (Q13, Table 5.2). 243 (74%) agreed that their colleagues gave them support and helped when they encounter difficulties at work. 277 (84%) out of the 299 (91%) who responded to the question said they helped other colleagues when they finished their work (Q14, Table 5.2).

However, figures dropped when asked if everyone's workload was equal in their team. 297 (90%) responded to this question. Of those, just over half - 152 (51%) agreed that everyone's workload was equal, ninety-two (31%) disagreed on this point and fifty-three (18%) claimed they didn't know. This has risen an interesting point that whilst 261 (87%) of the respondents felt

they were a member of the team, 242 (51%) agreed that their department worked very efficiently, only half, 152 (51%) respondents thought everyone received the same workload. According to the interview with the Head Nurse, each nurses' work is allocated by the departmental head nurse based on skills, experience and availability.

Table 5.2 Attitudes towards co-workers

To what extent do you agree that…

No	Question	Attitudes towards co-workers					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	your department works very efficiently.	32% (105)	42% (137)	11% (37)	5% (16)	0.6% (2)	10% (33)
2	you are a member of the team.	38% (124)	42% (137)	8% (26)	2% (8)	0.6% (2)	10% (33)
3	everyone in your department works together and you have a high morale.	29% (94)	42% (138)	15% (48)	5% (16)	0.3% (1)	10% (33)
4	you have a harmonious working relationship with your colleagues.	33% (108)	46% (153)	8% (27)	3% (9)	0% (0)	10% (33)
5	in your team, everyone's workload is equal.	13% (44)	33% (108)	16% (53)	21% (68)	7% (24)	10% (33)
6	everyone has a good working relationship in your team.	28% (93)	44% (146)	13% (44)	4% (12)	0.3% (1)	10% (34)
7	you and your colleagues work together to reach targets and to finish tasks.	25% (83)	49% (160)	12% (38)	5% (16)	0% (0)	10% (33)
8	when at work, you communicate with your colleagues smoothly and on time.	26% (84)	52% (172)	9% (30)	2% (6)	0.6% (2)	11% (36)
9	you have lots of disagreements conflicts and misunderstandings with your colleagues.	3% (10)	6% (21)	11% (36)	43% (142)	27% (88)	10% (33)
10	there is a lot of competition between colleagues.	4% (12)	18% (58)	31% (103)	29% (94)	9% (30)	10% (33)
11	you can express your thoughts and opinions freely about work.	10% (32)	40% (133)	22% (72)	13% (42)	5% (16)	11% (35)
12	you colleagues respect your opinions and feelings.	12% (38)	50% (166)	22% (71)	6% (19)	0.3% (1)	11% (35)
13	your colleagues will give you special support and help if you meet difficulties at work.	19% (64)	54% (179)	12% (40)	2% (8)	2% (5)	10% (34)
14	you help other colleagues when you have finished your work.	25% (83)	59% (194)	5% (17)	0.9% (3)	0% (0)	10% (33)
15	you are a member of the big family (the hospital).	26% (87)	41% (135)	12% (39)	6% (21)	5% (15)	10% (33)

No respondent strongly disagreed with the statement “you and your colleagues work together to reach targets and to finish tasks”, 243 (74%) said they would work together to reach targets. The result of the question “your colleagues will give you special support and help if you meet difficulties at work” is in line with the findings from my previous research that nurses were willing to and had always helped their colleagues when they met work difficulties, even the lazy ones and the managers’ favourites. 243 (74%) agreed with the statement. Most of the nurses in each department were allocated their own responsibilities and tasks, they did not spend much of their working time with co-workers. 277 (84%) respondents said they helped other colleagues when they had finished their own work.

Nurses were asked if they communicated with their colleagues smoothly and timely, 294 (89%) responded. Of those, 256 (78%) agreed with the statement. Only two (0.6%) strongly disagreed with the statement. Thirty-six (10.91%) respondents did not feel they were a member of the big family and fifty-eight (18%) said they could not express their thoughts and opinions freely about work.

Chinese believe that the most important thing of being successful at a work place is judged by whether one could get along with colleagues, be understood by co-workers and that harmony is maintained. Findings evolved from this study were the positive attitudes of nurses towards their co-workers which echo many previous studies on the subject (Wang 2002; Wang et al., 2012). Nurses in this study showed similar attitudes towards their co-workers

as the car workers in Goldthorpe's study. In both cases, workers maintained positive relationship with their co-workers, supported one another with work issues, and worked towards a common goal. They viewed co-workers as their workmates who carry out same tasks within work, but not necessarily as their 'close friends' outside work. So for the purpose of their job, they communicated, collaborated and minimised conflict with their team members. This no doubt have contributed positively towards patient care as the Joint Commission (2008) pointed out that the quality of patient care relies on collaborative work environment.

5.3.3 Nurses' attitudes towards management

Managers' attitudes towards workers can often affect how the workers feel towards management which ultimately plays a role in the workers' attitudes towards their work. It is suggested that nurses' productivity, job satisfaction and organisational commitment can be positively associated with the way they rate their managers (Duffield *et al.*, 2010; Tennant, 2015; Yang *et al.*, 2017). Nurses working in hospitals and other healthcare organisations are more interested in considerate and kind leadership, "they are more likely to commit to an organisation if their manager challenges the job, questions the *status quo*, handles stress well, experiments and takes risks" (McNeese-Smith, 1993).

Nurses that participated in this research were asked "do you agree that your attitude and enthusiasm towards work is affected by how your line manager treats you", 247 (75%) respondents agreed with the statement; only twenty-

one (6%) respondents answered negatively towards the statement (Q22, Table 5.3). This highlights the importance of managers' way to manage and communicate with nurses and how it could affect nurses' feelings about their everyday work. As it is noted that nurse managers should use measures including communicating with nurses positively, encouraging nursing innovation and empowering nurses to do jobs effectively to increase job satisfaction which ultimately improves quality of care (Liu *et al.*, 2012; Wang *et al.*, 2012).

As mentioned earlier, it is suggested that in industries and jobs where it is possible to predict work processes, programmatic decision-making will reduce job autonomy, while in industries and jobs where it is not possible to predict work process, job autonomy will be increased (March and Simon, 1958). One can argue that a standard shift of a nurse's work in a non-emergency ward is predicable, which results in a more defined work process and less autonomy, whereas a nurse in accident and emergency unit may have a higher degree of autonomy in order to react to immediate situations with less programmatic decision-making (Mather and Seifert, 2017). The respondents of this research all worked in non-emergency, in-patient wards. Their shifts were allocated by the departmental head nurses, their tasks were also assigned by head nurses. These nurses generally did not have a say in what they did, how they did it and when they did it. Yet, only 178 (54%) respondents agreed that their line manage could assign tasks fairly (Q5, Table 5.3). This finding is surprising as it indicates that in an environment where nurses do not have much say in when they go to work, how they work,

they have to rely on and trust their managers to treat everyone equally, but only half of the respondents thought their managers could assign tasks fairly. This further suggests that nurses were dissatisfied with the way their managers worked, which as indicated in Q22 (Table 5.3) ultimately affected their attitudes and enthusiasm towards work. I feel this was one of the few highly sensitive and touchy subjects for both nurses and nurse managers. In a previous research (Feng, 2007), nurses had raised the issue of unfair workload being assigned to them by their managers simply because they were not the managers' favourites.

It had appeared to me that everyone knew that certain people would be assigned light shifts or easy tasks, but no one felt they could do anything about it. The respondents were also asked if they agreed that their line manager treats everyone equally, 295 (90%) respondents gave an answer. Of those, thirty-five (12%) strongly agreed, a further 162 (55%) agreed, sixty-eight (23%) said do not know, forty (13.56%) disagreed whilst twenty-seven (9.15%) strongly disagreed (Q3, Table 5.3). This is indicative that whilst just over half of the respondents felt fairness was applied in their daily work, there were still quite a large number of nurses who still believed that not everyone was treated equally. This may be caused by favouritism (Rosenbaum and Walsh, 2012), a long standing issue found between managers and workers in Chinese organisations. Workers usually talk about it among each other, but no one is quite brave enough to bring it up with their managers or is ready to face the consequences it may lead to.

During my interviews with the departmental head nurses, they told me issues around pay and workload were the biggest challenges and difficulties they faced in nurse management. This was documented in my previous research (Feng, 2007) when I spoke to eight nurses about favouritism. I asked if management used bonus to reward their favourites, half of the interviewees said they did not know about it, while the other four gave a confirmative answer; two of the interviewees in that research said that they personally knew their managers had once used bonus to award their favourites. I asked how the mangers was able to do that as the information I gathered through the research indicated that everyone received more or less the same bonus, if they had worked enough hours. One of them explained to me:

> "I personally know that there are many ways of doing that, and the most obvious way and also the one way we have found out was that managers usually give their favourites easy working hours and shifts; managers have so many ways of doing this, there's nothing you can do to stop them, and they can always find reasons for why they do so". (Feng, 2007)

When the interviewee said "easy hours and shifts", it referred to the less busy hours in the evenings and easy tasks. A couple of the other nurses interviewed for my previous research said:

> "managers have always given training opportunities to their favourites, as you know, a lot of training programmes in China are considered to be a 'semi-holiday training' which take place in a resort, which means

the managers' favourites not only do not have to work, but they also get the same bonus pay plus extra holidays." (Feng, 2007)

These findings suggest that favouritism exists in nurses' everyday life, but because nurse managers have enough amount of authority and power to manage such conflicts in work situations, and to justify their behaviours, nurses choose to avoid confronting it. This was found in similar nurse and nurse manager conflict studies (Hightower, 1986; Cavanagh, 1991). Also, nurses who use accommodation to manage conflict between themselves and their managers turn out to be less satisfied with their work (Kunaviktikua *et al.*, 2000; Wang *et al.*, 2012).

Trust is another factor which is likely to cause tension between workers and management (Altuntas and Baykal, 2010; Su-Yueh Chen *et al.*, 2015; Fard and Fariba, 2015; Hsu *et al.*, 2015). This research found less than half respondents, 146 (44%), agreed that their line manage completely trusted them; 112 (34%) said they did not know or did not think they were trusted by their managers (Q9, Table 5.3). When throwing the question back to the respondents, 179 (54%) of them said they trusted their line manager (Q16, Table 5.3). This shows that more than half of the survey nurses trusted their managers but less than half of them felt the same way about their managers trusting them. The direct contact between nurses and their managers, specifically their direct line-manager, plays an instrumental role in creating a positive work climate (Shirey, 2004; Aly and El-Shanawany, 2016).

Table 5.3 Attitudes towards management

To what extent do you agree that…

No	Question	Attitudes towards management					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	management in your department is fair, equal and open.	11% (35)	37% (121)	19% (62)	16% (51)	8% (26)	11% (35)
2	Managers in your department have a good working relationship with the staff.	15% (50)	49% (162)	17% (55)	6% (21)	2% (6)	11% (36)
3	your line manager treats everyone equally.	11% (35)	38% (125)	21% (68)	12% (40)	8% (27)	11% (35)
4	your line manager has very high professional nursing skills.	17% (55)	46% (152)	18% (58)	6% (20)	3% (9)	11% (36)
5	your line manager can assign tasks fairly.	11% (37)	43% (141)	19% (63)	10% (34)	6% (21)	10% (34)
6	your line manager pays attention to your opinions and suggestions.	12% (38)	38% (126)	26% (84)	12% (39)	3% (9)	10% (34)
7	your line manager understands what you do and how you perform at work.	13% (43)	46% (153)	21% (68)	7% (23)	2% (8)	11% (35)
8	you are very willing to communicate with your line manager.	14% (45)	42% (138)	20% (67)	12% (39)	2% (6)	11% (35)
9	your line manager completely trusts you.	9% (31)	35% (115)	34% (112)	6% (20)	5% (15)	11% (37)
10	you meet your line manager regularly.	9% (30)	31% (103)	20% (65)	22% (74)	6% (20)	12% (38)
11	you enjoy working with your line manager.	10% (34)	37% (123)	24% (78)	14% (47)	4% (13)	11% (35)
12	your line manager praises and encourages you when you are making progress.	13% (43)	51% (168)	15% (50)	8% (26)	2% (8)	11% (35)
13	Your line mangers praises you when you make achievements.	12% (40)	50% (166)	19% (61)	7% (22)	2% (6)	11% (35)
14	your line manager will give you support and help if you meet difficulties at work.	14% (46)	47% (156)	19% (61)	8% (26)	1% (4)	11% (37)
15	your line manager will most certainly help you if you need it.	16% (51)	48% (158)	20% (65)	5% (16)	2% (5)	11% (35)
16	you trust your line manager completely.	13% (44)	41% (135)	23% (77)	9% (31)	2% (7)	11% (36)
17	your line manager gives you enough support.	14% (45)	43% (141)	21% (70)	8% (26)	3% (10)	12% (38)
18	your line manager criticises you a lot.	2% (7)	10% (32)	16% (53)	47% (155)	13% (43)	12% (40)
19	your line manager can resolve all the conflicts at work.	8% (25)	48% (158)	22% (72)	8% (27)	3% (9)	12% (39)
20	your line manager can help you improve your work skills and abilities.	9% (29)	42% (138)	27% (90)	9% (30)	2% (7)	11% (36)
21	you feel that your line manager respects you.	11% (37)	46% (151)	23% (77)	7% (22)	2% (7)	11% (36)
22	your attitude and enthusiasm towards work is affected by how your line manager treats you.	25% (82)	50% (165)	8% (26)	5% (16)	2% (5)	11% (36)

As Ribelin (2003, p.18) states that “nurses do not leave hospitals, they leave managers”. Respect between nurses and their manager is linked to whether a nurse is likely to leave work. The findings from this research is in agreement with many previous studies, (Kiefer, 2005; Wong *et al*., 2005; Sayed and Ibrahim, 2012; Ismaiel *et al*., 2013; Aly and El-Shanawany, 2016), which suggest trust and respect, compared with structural aspects of the work interactions with nurse managers can play a big part in nurses’ decisions to leave their jobs.

As seen in Q21 (Table 5.3), 188 (57%) respondents said their line managers respected them. Less than half, 156 (47%), respondents agreed with the statement “management in your department is fair, equal and open” (Q1, Table 5.3); whilst twenty-four (24%) did not agree that their department was fair, equal and open. In terms of managers relationship with their staff, 212 (64%) respondents thought managers in their department had a good working relationship with the staff, only twenty-seven (8%) respondents disagreed; there was a relatively high ratio of respondents who said they did not know the answer to this question – fifty-five (17%), which could show that they disagreed with this statement but did not want to express a view (Q2, Table 5.3). The head of the hospital thought relationship between managers and their staff is not easy:

> “In the west, your boss is your boss who you obey, your colleague is your colleague who you respect, then you get on with your work, everything is very straight forward. The relationship between

> colleagues or bosses is simple. …In China, such relationships are way too complex. People screw each other up. It is very difficult."

Departmental head nurse 3 said the biggest challenge for her when managing nurses is: "Nurses are very busy during their work hours, I feel wrong to then tell them how to do their job better."

Favouritism is regarded as one of the reasons why workers are less willing to cooperate with management. In my previous research (Feng, 2007), nurses expressed that they were less willing to cooperate with management because they felt no matter how hard they worked or how cooperative they were, managers would always award those who they liked. Nurses did not feel appreciated by their managers, and that was reflected by the amount of bonus they received, as well as the verbal praise they were given by their managers. Similar findings are shown in this research, only around half of the nurses' trusted their managers and felt trusted, but there was a lack of evidence to show nurses' attitudes towards their managers did not affect their actual work and care quality.

Overall, nurses in this study resembled similar attitudes towards management as the car workers sampled in Goldthorpe's study. In both cases, worker-manager relations in general were relatively smooth. Workers felt need for personal recognition and approval from their managers and that where this need was met a positive response would be given by the workers. But as manager in workplaces usually embodies management within the

system, any dissatisfaction towards policies is directed at mangers and that may affect relationships between workers and management.

5.4 Professionalism – nurses' attitudes towards nursing profession

It was only until after the recent "changes in philosophies and the structure of nursing, the educational pathways for nurses, the health care system, and society have led to generalised recognition of nursing as a profession" (Thompson, 2012, p.159). Both nursing education and the profession are changing in China. The Chinese government has introduced a nationwide series of Higher Education Quality projects to give funding to institutes allowing for training programmes such as nursing competency training models, nursing demonstration laboratory centres, and nursing specialty development. These projects focused on the construction of humanistic education framework, the improvement of nursing students' critical thinking ability, the progress in evidence-based practice and the overall better integration of theory and practice.

There is also a developing trend of increasing nurses' qualification, to help improve the overall ability of nursing force in China (Li, 2001; Li and Shang, 2009; Ma and Liu, 2009; Wong and Zhao, 2012; He *et al.*, 2013; Wang, 2016). Findings of this study suggest that nurses' attitude towards pay is directly linked with their job satisfaction and retention, which can also change their view of the profession. Nurses' attitudes towards pay and bonus scheme, and towards general terms and conditions, including job evaluation

and appraisal, training and personal development, and career development, will be discussed in the next chapter.

For those in the nursing profession, nurses' image has always been a concern. The decision to enter nursing, to remain in nursing and to promote nursing, may be the result of nurses' perception of the image of the profession. In China, nurses are often described as 'White Angles' for their generous contribution to public health, nurses' value and importance to the society was greatly reaffirmed during the outbreak of SARS (Severe acute respiratory syndrome) in 2003 (Liu *et al.*, 2004). There has been a growing recognition of the professional status of nurses. In 1980s, the Chinese government reaffirmed that nursing was an independent profession, just like medicine, which required qualified personnel. The government also showed recognition of nursing as an independent profession and has established university degree nursing programmes. Such development by the government has improved the nursing professional status (Li, 2001).

Previous studies found that nurses' image was associated negatively to their intention to quit the job, and that the image of nursing perceived by nurses and by the public, affect new nurses' recruitment and experienced nurses' retention (Buerhause *et al.*, 2005; Takase *et al.,* 2006), and the dissatisfaction of nurses with their professional image of nursing is a major factor that contributes to the nursing shortage (Kimball and O'Neil, 2001). The general public has vague notions of what nurses do (Akase et al., 2006), so typically, nursing students begin their nursing education with a

stereotypical, inaccurate image of nursing (Emeghebo, 2012). Many who enter nursing do not initially aspire to be nurses, and only consider the field of nursing when they are not doing well in another major in college. Their decision to become nurses is based on that nursing is a respectable profession but not a highly educated one. Nurses usually begin their career in nursing with a generally positive image of nursing.

However, participants in the questionnaire were asked if nurses had high social status, 294 (89%) answered the question. Of those, only twenty-four (8%) agreed that nurses have a high social status, 150 (51%) strongly disagreed that nurses have a high social status (Q2, Table 5.4). When asked if nurses' contribution to society is invaluable, 293 (89%) participants answered the question. Of those, 233 (80%) agreed that nurses' contribution to society is very important (Q3, Table 5.4). These findings are in line with the results shown in the latest jointly released White Paper (2017) by the China Social Welfare Foundation, the Nurse Caring Plan and other groups. The White Paper found around 81% of its sampled nurses valued 'being respected' the most important element of their job; nearly all sampled nurses believed the 'social status of nursing jobs is too low'; over 83% could not directly feel the respect from patients to nurses and 90% could not directly feel the respect from the public, despite the reports on the public's growing recognition of nurses' importance to society.

The vast majority of the public thinks the main part of nurses work is do drug rounds and give injections, but only have a very vague understanding of the

concept that nurses are capable of giving nursing diagnosis, making and implementing nursing plans (The White Paper, 2017, China). It is often argued that people can develop devotion to their profession if they think the profession is valuable (Altschul, 1979). 125 (38%) of respondents agreed that the work they do was satisfying and worth it (Q13, Table 5.4). Participants were also asked if they felt a sense of achievement from their work. 296 (90%) responded. Of those, 151 (51%), which was over half felt a sense of achievement from their work (Q23, Table 5.4). According to the findings of this research, 41% of the surveyed nurses were dissatisfied with their work (Q13, Table 5.4). This suggests that the level of dissatisfaction of their job among Chinese nurses remain high, as described in the study by You *et al.* (2012), which found over 45% of nurses were dissatisfied with their jobs.

Job satisfaction is described as all the feelings that an individual has about their job (Spector, 1997). Participants were asked if they were happy when they were working. 293 (89%) responded. Of those, 138 (42%) said they were happy when they were working; eighty-six (26%) disagreed with this statement, sixty-nine (21%) stated they didn't know (Q4, Table 5.4). Participants were also asked if they worked hard. 271 (92%) out of the 295 (89%) who responded to this question stated they did work hard. Many quantitative as well as qualitative studies have been conducted in the attempt to find the sources of job satisfaction among nurses. Lu *et al.* (2007) summarised the findings from such research and found that the sources of job satisfaction included, *inter alia*, working conditions (Adamson et al., 1995;

Nolan et al., 1995), interactions with patients/co-workers/managers (Lee, 1998; Aiken *et al.*, 2001), work itself (Lundh, 1999; Adams and Bond, 2000), remuneration (Price, 2002; Wang, 2002), self-growth and promotion (Tzeng, 2002a, b), praise and recognition (Nolan *et al*., 1995; Lundh, 1999), control and responsibility (Lee, 1998; Price, 2002), job security (Nolan *et al*., 1998) and leadership styles and organisational policies (Lee, 1998; Tzeng, 2002a, b).

Participants in this research were asked if they were satisfied with their work and it was worth the efforts, 293 (89%) responded to this question. Of those, 125 (43%) stated they were satisfied with their work and it was worth the effort (Q13, Table 5.4). That shows that less than half of the nurses who took part in this research were happy with their work. 293 (89%) survey nurses responded to the question “To what extent do you agree that your skills are brought into full play”. Only 118 (36%) said their skills were brought into full play; eighty-eight (27%) said they did not know; 87 (26%) did not agree with the statement (Q16, Table 5.4). 294 (89%) responded to the question that you felt a sense of achievement from your work. Of those, 151 (51%) answer positively, sixty (20%) said they did not know; eighty-three (28%) did not get a sense of achievement from their work (Q23, Table 5.4).

Job stress is a “harmful response physically and emotionally” when the employee’s skills, resources and needs could not fulfill the requirement of the job, according to the U.S. National Institute of Occupational Safety and Health (Yau *et al.*, 2012, p.61). As seen in Table 5.4, 295 (89%) answered

the question about if feeling stressed when at work. Of those, 214 (73%) stated they felt stressed when at work; only 11 (4%) disagreed with the statement (Q8, Table 5.4). Participants were also asked if they feel stressed because of work. 294 (89%) responded to this question. 232 (70%) agreed that they felt stressed because of work; only three (less than 1%) respondent stated that they did not feel this way (Q7, Table 5.4). This shows over two-thirds of respondents were stressed at work and were suffering from stress caused by work, which is similar to the findings in Dailey's (1990) study in America and Fang's (2001) study in Singapore. Xianyu and Lambert (2006) pointed out Chinese nurses work under great pressure caused by workload, poor staffing, dealing with death and dying, and conflict among co-workers. Yau *et al.* (2012) study showed workload and time conflicts were the most serious sources of stress and this was supported by studies done by Li and Liu (2000), Xianyu and Lambert (2006), Zeng (2009), and Sayed and Ibrahim (2012).

Participants of this study were asked if they were happy with their working hours and overtime policy, 293 (89%) participants responded of whom 125 (43%) said they were happy, and 118 (35%) disagreed with this statement. Participants were asked if their work was difficult and there was always a lot to do. 293 (89%) answered this question. Of those, 224 (76%) agree with this statement, only five (2%) respondents strongly disagreed that their work was difficult and there was always a lot to do.

In the twelve interviews with the head nurses, eleven said they did not have enough nurses. The surgical department at the case study hospital at the time of research had twenty in-patient wards. The head nurse for the surgical department was responsible for the overall management of all the nurses working in these twenty wards. At the time of the interview, she was responsible for all the head nurses in each ward plus the fourteen nurses in her own ward, which meant that she had a total of thirty-four employees whom she line-managed. When asked if she had enough nurses in her ward, she said:

> "No, we don't have enough nurses. There are different requirements for nursing care – if we want to optimise nursing care by reaching the international nursing standards and making patients 100% satisfied, then there are not enough nurses to do so. I think if we could get three to four more nurses, the quality of nursing care would be improved."

She also explained the factors which increase nurses' workload these days:

> "Overall, there's a shortage of nurses, not enough nurses to cover the massive workload. Especially for some of the wards, there are so many patients; we have to add extra beds in the wards, so nurses will have to take on extra work. Another thing is that these days patients are prescribed a lot of drugs, whereas in the past patients didn't have as many injections or drips; this means now nurses have to spend much more time on treatments compared to how it used to be. As a result, the nursing care side of things are not done properly."

The research found that all the head nurses had a great amount of line managing responsibilities. Out of the twelve interviewed head nurses, the one who had the highest number of direct reports managed seventy people; the one with the least number of direct line reports, comparatively speaking, still had fourteen. As examined by Xianyu and Lamber (2006), head nurses in Chinese hospitals need to adapt to more complex and difficult roles as a result of the health care system reform. Another study found that nurse managers reported a huge level of stress raised from the nature of the job and work-life imbalance with little support in the workplace (Shirey *et al.*, 2008).

Head nurses in China are expected to take part in nursing education, research, finance management, supply preparation, dispute handling and collaboration with other staff members, which are complex activities besides patients' quality care maintenance (Xianyu and Lambert, 2006). One of the head nurses interviewed who line managed fifty-two nurses said she did not have enough nurses:

> "especially when someone is off sick or is on maternity leave. Although, if you look at the big numbers, I count enough people heads for the number of beds in the wards, but two out of fifty-two do not nurse, so we need another couple of nurses at least. The head of my department has requested to recruit five more nurses this year and it has been approved by the hospital. So that gives us three nurses to cover sick leave and maternity leave."

Table 5.4 Attitudes towards nursing

To what extent do you agree that…

No	Question	Attitudes towards management					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	you like nursing.	12% (41)	36% (118)	15% (48)	15% (50)	11% (36)	11% (37)
2	nurses have high social status.	0.9% (3)	6% (21)	5% (17)	31% (103)	45% (150)	11% (36)
3	nurses' contribution to society is invaluable.	36% (120)	34% (113)	5% (18)	6% (19)	7% (23)	11% (37)
4	you are happy when you are working.	10% (34)	32% (104)	21% (69)	20% (65)	6% (21)	11% (37)
5	your work is difficult and there's always a lot to do.	40% (98)	38% (126)	8% (27)	11% (37)	2% (5)	11% (37)
6	you work very hard.	53% (174)	30% (97)	4% (14)	2% (8)	0.6% (2)	11% (35)
7	you feel pressured because of work.	32% (104)	39% (128)	7% (22)	11% (37)	0.9% (3)	11% (36)
8	you feel stressed when at work.	28% (92)	37% (122)	10% (32)	12% (38)	3% (11)	11% (35)
9	you feel bored when at work.	7% (22)	15% (50)	14% (45)	40% (132)	13% (44)	11% (37)
10	you have enough time to finish the work you are assigned to do.	7% (22)	29% (96)	17% (56)	27% (88)	9% (30)	12% (38)
11	you fully understand your work responsibilities and targets/goals.	25% (83)	45% (147)	10% (34)	7% (23)	2% (8)	11% (35)
12	the work you are doing is challenging.	10% (33)	33% (110)	19% (63)	22% (72)	5% (16)	11% (36)
13	you are satisfied with your work and it's worth it.	8% (27)	30% (98)	21% (68)	22% (72)	8% (28)	11% (37)
14	you take on a lot of responsibility at work.	37% (121)	43% (141)	4% (13)	4% (13)	2% (5)	11% (37)
15	you feel distracted at work.	1% (4)	6% (21)	7% (24)	44% (144)	31% (101)	11% (36)
16	your skills are brought into full play.	5% (17)	31% (101)	27% (88)	20% (67)	6% (20)	11% (37)
17	you have enough skills and techniques to do your job.	20% (66)	52% (172)	12% (38)	3% (11)	1% (4)	12% (39)
18	you have enough confidence to do your job.	26% (85)	47% (155)	12% (40)	3% (11)	1% (3)	11% (36)
19	you know where to get the information you need at work.	11% (35)	44% (146)	23% (77)	9% (28)	2% (5)	12% (39)
20	you are happy with your working hours and overtime policy.	11% (35)	27% (90)	15% (50)	23% (77)	12% (41)	11% (37)
21	you are satisfied with your annual leave.	8% (25)	14% (46)	14% (47)	25% (82)	28% (92)	12% (38)
22	the hospital recognises the work you do and your contribution to its operations.	6% (21)	30% (98)	30% (99)	15% (49)	8% (25)	12% (38)
23	you feel a sense of achievement from your work.	10% (33)	36% (118)	18% (60)	16% (53)	9% (30)	11% (36)

Chinese nurses in management roles are expected to tackle the clinical workload and to oversee and manage multiple administrative tasks. It is also argued that lack of training, resources, excessive paperwork and limited shared governance in decision making also contribute to the nurses' work-related stress (Welker-Hood, 2006). 291 (88%) responded to the question of whether they felt they had enough skills and techniques to do their job. Of these, 238 (72%) stated that they had enough skills and techniques to do their job (Q17, Table 5.4). When asked if they had enough confidence to do their job, 240 (82%) of the 294 (89%) who responded said they had enough confidence to do the job (Q18, Table 5.4). Over half of the respondents, 181 (55%), indicated that they knew where to get the information they needed at work (Q19, Table 5.4). All twelve of the departmental head nurses said they did not take part in the recruitment process for nurses, and they did not have any say in terms of how many nurses or the types of nurses they were allocated. The hospital HR team is in charge of the whole recruitment process.

Participants were asked if they were satisfied with their annual leave entitlement, 292 (84%) surveyed nurses answered the questions, of those, only seventy-one (24%) were happy with their annual leave entitlement (Q21, Table 5.4). When the participants were asked if they had enough time to finish the work assigned to them, 292 (85%) answered the question, only 118 (40%) of those who responded said they had enough time to finish the work assigned to them (Q10, Table 5.4), in other words, more than half of the surveyed nurses felt they were not allocated enough time to finish their work.

This again echoed the phenomenon of nurse shortage in Chinese public sectors hospitals, which may lead to increase in nurses' workload. It is important to note that nurses' workload is another major work-related stressor that is highlighted in job satisfaction studies in many countries (Aiken *et al.*, 2001; Lambert *et al.*, 2004; Khowaja *et al.*, 2005). 271 (82%) of the 330 researched nurses said they worked very hard at work (Q6, Table 5.4), but only 119 (30%) of them thought the hospital recognised their work and achievement (Q22, Table 5.4).

Participants were asked if they fully understood their work responsibilities, targets and goals. 295 (89%) responded. Only thirty-one (11%) of those disagreed with the statement, the overall majority understood their responsibilities (Q11, Table 5.4). However, when asked if the work they were doing was challenging, only 143 (49%) people out of the 294 (89%) who responded agreed with the statement (Q12, Table 5.4). 293 (89%) responded when asked if they took on a lot of responsibility at work. Of those, the vast majority, 262 (89%), said they took on a lot of responsibilities, only 18 (6%) disagreed with the statement completely (Q14, Table 5.4). This suggests that nurses believe they take on a lot of responsibilities at work, and that they have the right skills to carry out the work.

The UK and the USA are among several developed countries currently experiencing severe nurse shortages (Buchan *et al.*, 1997; Sibbald, 2000; Han, Trinkoff and Gurses, 2015). Nurse shortage has long been a problem in the developed countries such as the UK and the USA and it has become a

serious problem in Chinese hospitals (Hu, Chen and Jiang, 2010; Chan *et al.*, 2013; Liu *et al.*, 2013). The head of the hospital and the hospital head nurse both gave a very definite answer to whether or not the hospital had enough nurses. The head nurse explained that the hospital had 1,000 in-patient beds, and according to the World Health Organisation's rule which is one patient per nurse, that means the case study hospital needed to have 1,000 nurses, this meant the hospital did not have enough nurses.

Both the head of the case study hospital and the head nurse talked about the issues around nurses on fixed-term contracts. The hospital had 827 nurses on fixed-term contracts, and most of these fixed-term contract nurses were previously known as 'temporary nurses'. Temporary work in China is not what is considered as part-time work, temporary worker does not usually get any contract, and it is more of a verbal contract agreed between the line manager and the worker. In this case, the worker does not get sick pay, holiday pay or pension and is not eligible for the bonus scheme. This type of employment has been very common in China and is still widely seen. The government finally issued a series of policies and law to protect workers' rights. The head nurse said the new Labour Law in China does not allow hospitals to recruit any temporary nurses. The case study hospital had been switching its existing temporary nurses into fixed term contracted nurses since 2007. The hospital recruited graduates with an undergraduate degree in nursing from state-owned universities and medical colleges every year, and it also recruited contract-based nurses with a three-year college diploma in nursing from local medical and nursing colleges. All temporary nurses

must hold at least a three-year college diploma to work in the hospital. According to the MOH (MOH, 2008), China introduced baccalaureate nursing education much later than many other countries and those who work in Chinese with such degree only make up 3% of the nursing staff.

Apart from the qualification requirement, the hospital did not set any other special requirements when recruiting nurses. The head nurse said it had been become more and more difficult every year to recruit nurses, because there are new private hospitals and clinics that were recruiting nurses and they normally offer a better pay scale than state-owned hospitals. But the hospital did not lower its standards in requirements as a result of this competition; training and assessment were given and required when recruiting new staff. The head of the hospital explained why they could not simply just recruit more nurses to help with the shortage of staffing:

> "It's not that we don't want to recruit enough nurses to do the job – I don't know what it is like in the UK, but during my visits to the USA, I learned that a standard American hospital with 800-1,000 beds first of all has a much higher discharge rate than us, their patients are usually in the hospital for 3-4 days; at the same time such hospitals have a very low outpatient number, their average annual outpatient and emergency patient figure combined is about 200,000 (I'm not sure about the situation in the UK – Feng says 'the figure is lower than that in the UK'). But in China, a hospital with 1,000 beds receives nearly one million outpatients a year. If you look at the number of staff in

such an American hospital, including doctors, nurses and workers, it's usually around 5,000. So what is the situation here in our hospital?

We have 1,650 beds, receives 1 million outpatient a year, the total number of staff is just a little over 3,000. Out of those 3,000, 700 - 800 are retired so that means we only have about 2,200 staff doing all the work. So how do we compare with a hospital in the west? The answer is we can't! You probably know this as you live in the UK, in their health system or structure, most doctors probably only see 10 outpatients each morning, patients like yourself will have to make appointments and just wait. So comparatively speaking, their efficiency is a lot lower than ours. When you go to a hospital in the west, you always see more staff than patients; there are plenty of staff on wards and you hardly ever see patients' families there 24/7; for outpatients, strict appointment slots are followed, one at 9am, one at 9:30 and the one after than 10:00; this means you never see lots of people in the hospital. Whereas here, as you know, our hospital is like a market! So again, these are the issues which come with the different health systems and structures.

So the root as to why we have not recruited enough nurses is the medical cost issue. But to be honest, I don't have the exact nurse-to-bed ratio number on top of my head, but I'm sure the nursing department will be able to tell you the figure (1:1.5). There is a general ratio level, but the level changes depending on the exact job, for

example the ratio level will be higher for intensive care unit and coronary care unit. One thing I am certain is we currently do not meet the government's general requirement of nurse-to-bed ratio but we are not far off."

This provided an insight that despite the government's efforts to decentralise control, and to give more power in decision making on matters include, recruitment, reward and performance (Liu *et al.,* 2006), hospitals still had little management autonomy in recruitment and selection process as well as performance management. This is caused by an incomplete policy adjustment in areas of employment and welfare policy (Pet *et al.*, 2000). Although it has become possible for hospitals to manage its internal staffing, reward and training, the number of new doctors and nurses a hospital can recruit is still subject to local authority's quotas. Also, the Party's influence remains in all public service organisations at all levels, medical institutions included.

5.5 Conclusion

This chapter presented the questionnaire and interview findings in relation to nurses' working lives. Findings and discussions focused on nurses' attitudes to others, including attitudes to patients, to co-workers, to management and to the nursing profession.

Changing job boundaries and workers' task allocation decisions are intertwined with the debates about who may be employed, how many,

training requirements, and performance management. The new nursing ideology has shifted from one nurse performing the same allocated tasks on different patients repeated through a working day, to a nurse providing all the care needed by the patient (Allen, 2001). The same is taking place in China. Under the government's new patient-centred care scheme, patients are given more rights than ever before, but it had not always been the case. In the past, under the influences of traditional Chinese culture, doctors and medical staff always had higher social status than patients. But only half of the participants in this study felt respected by patients, and the poor patient-to-nurse ratio was blamed for affecting not only nurses' job satisfactions, and also poorer or fair quality of care.

Driven by Confucianism (Yao, 2000), Chinese nurses strive to keep a harmonious relationship at workplaces with their co-workers, to avoid conflict (Kirkbride and Tang, 1992). This was largely true in the case study hospital, but findings suggested individuals did not always feel they were fairly treated by management. It is suggested that nurses' productivity, job satisfaction and organisational commitment can be positively associated with the way they rate their managers (Duffield *et al.*, 2010; Tennant, 2015; Yang *et al.*, 2017). Job autonomy was relatively low in the case study hospital – nurses' shifts were allocated by the departmental head nurses, and their tasks were also assigned by head nurses. These nurses generally did not have a say in what they did, how they did it and when they did it. Only half of the respondents thought their managers could assign work fairly. This finding was surprising because it suggested that in an environment where nurses did not have

much say in their work, they had to rely on and trust their managers to treat everyone equally, but as only half of the respondents thought their managers could assign tasks fairly, nurses were dissatisfied. This could damage the trust between workers and managers, cause tension, and also affect nurses' attitudes and enthusiasm towards work.

With both nursing education and profession changing in China, the Chinese government has introduced a nationwide series of Higher Education Quality projects to give funding to institutes allowing for nurse training programmes to take place. These projects focused on the construction of humanistic education framework, the improvement of nursing students' critical thinking ability, the progress in evidence-based practice and the overall better integration of theory and practice. There is also an increasing trend of increasing nurses' qualification, to help improve the overall ability of nursing force in China (Ma and Liu, 2009; He *et al.*, 2013; Wang, 2016). But findings of this study indicated that lack of training contributed to the nurses' work-related stress, which could lead to nurses leaving the profession.

This chapter tested two hypotheses: the nature nurses' work relations, including their relations with patients, co-workers and management; and the nature of the profession, as some of the relevant factors of nurses' attitudes to and at work. Through diving into Chinese nurses' working lives, this chapter investigated their relationships with people they have immediate contact with during their day-to-day work, including patients, co-workers and management. While vast majority of nurses in the study indicated they had a

harmonious relationship with patients and were enthusiastic to help patients, they also confirmed that patients could be rude and they had too many patients to look after. Nurses did not have a say in how their work was allocated or which patients they looked after because these decisions were made by management alone, and this led to only half of the nurses agreeing that their line manager could assign tasks fairly. But this did not affected nurses' acceptance of the teamwork view where everyone helped and supported each other regardless of unequal workload, similar to what workers in Goldthorpe's study suggested.

By analysing nurses' answers to their relationship with both co-workers and management, it was clear that nurses did not bring negative attitudes into work and that neither outcomes of these relationships affected nurses' ability to carry out caring work. In Goldthorpe's study, it was found that workers referred to high levels of pay as an important indicator to how they felt towards both the employer and the job itself. So to understand how nurses in this study feel about pay, especially how it affects their orientation towards the hospital as an employer, and towards future career development, the next chapter will focus on testing another hypothesis of this thesis -- the nature of the work situation, which includes contracts and pay determination, as a relevant factor of nurses' attitude to and at work, through looking at Chinese public hospital nurses' terms and conditions of their work, with a focus on pay and the case study hospital bonus scheme. It will also test the nature of the profession and the changes in terms of management and

training as some of the other relevant factors which affect nurses' attitudes to and at work.

Chapter Six

Chinese nurses' attitudes to work terms and conditions

6.1 Introduction

This chapter continues to explore some of the relevant factors of nurses' attitudes to and at work, particularly the nature of the work situation, this includes contracts and pay determination, pay and bonus scheme affect their attitude to work; and the nature of the profession and changes in terms of training and career development. The findings in this chapter come from both the questionnaires and the interviews.

Building on Goldthorpe's findings that workers referred to high levels of pay as an important indicator to how they felt towards both the employer and the job itself, this chapter goes straight into looking at one of the most studied themes of industrial relations – pay. It firstly reviews the purpose of pay and performance-related pay. Then it introduces the case study hospital pay system and bonus pay system; how nurses' pay is determined in Chinese public sector hospitals. Through looking at the findings, it details nurses' knowledge and pay and bonus scheme at the case study hospital. It also discusses how different employment contracts may impact on nurses' income.

The second part of this chapter deals with nurses' attitudes to job evaluation, training and career development. It introduces the case study hospital's 'three-tier quality control and management" job evaluation process, and its

effectiveness is explored. As the Chinese government is providing funding to institutes nationwide allowing for nurse training programmes to take place, it is rational to assume that nurses are receiving more training opportunities than ever before. This theory is tested in this research. Nurses' attitudes towards training and personal development are studied. The final section of this chapter looks at nurses' attitudes towards career development and their future as a nurse or potentially leaving the profession.

6.2 Nurses' attitudes towards pay and bonus scheme

One of the most studied themes of industrial relations is the issue around pay. It has long been accepted that workers expect to receive pay in exchange for the sale of their labour power. The complex process of pay determination is influenced and constrained by the labour market, the legal framework, employers' business strategies, and trade unions responses. Different from the technical solutions concentrating on an absolute wage level, the nature of pay and its determination are closely connected with the notion of relative wages and the power relations between employers and employees. "Pay relativities are a major source of contention in industrial relations, giving rise to problems at the plant and company level in collective bargaining and the national level in the management of income policies", says Marsden (1983, p.263). As Brown *et al.* pointed out "the management of pay, and of bargaining over pay, are of fundamental importance to the conduct of industrial relations", as "payment is the most conspicuous focus of collective concern for labour" (1995, p.123).

Pay is “the reward to the factor of labour production” and “the payment for work to the employer” (Robertson, 1961, p.3), and for most of people, it is simply “their principal incentive to work” (Flanders, 1975, p.72). Pay may include overtime rates, shift pay, bonuses, incentive pay arrangement, holiday rights, sick pay, employee benefits and dismissal compensation (Lester, 1964, p.256). Pay could simply be seen as a fair exchange between employees’ contribution and employers reward but it is never easy to define a figure that both the employees and employers find satisfactory. Flanders argues: “A job or employment contract represents in its economic aspect a wage-work bargain. The wage side of this bargain can be made specific with the help of the measuring rod of money, but the work side is within limits necessarily indeterminate” (Flanders, 1975, p.72-73).

A payment system is defined as “the set of rules which determine how much pay each individual shall receive by comparison with others in the same organisation” (Bowey, 1989, p.31). It includes basic pay and productivity bonus, while the pay structure refers to the hierarchy of pay which exists within an organisation. Through using job evaluation and work measurement, work is examined, and payment systems are designed to associate earnings to employees’ contributions (Bowey, 1989). There have been few studies of pay and nurses pay in the NHS using fieldwork evidence. Thornley (1993 and 1998) argued that decentralisation of collective bargaining was natural development to control labour cost in the historic reformulation of pay determination mechanisms.

PRP gives management greater control over the costs and performance of labour. There are two approaches that management may attempt to control the costs of PRP: operate a quota so that the numbers eligible for higher pay awards are limited and set a limit on the proportion of the pay bill available for PRP (French *et al*, 2001; ACAS, 2015). As for an organisation's interests, as Hyman and Brough (1975, p.14) illustrate, labour costs for employers is a cost of production, and so employers will try to maximise the contribution of an employee relative to a level of wage in order to reduce unit labour costs, and thus minimising wage costs with respect to a level of effort . Organisations, through setting up pay and performance bars, aim to improve workers' performance which makes further rewards dependent on obtaining higher performance.

The introduction of PRP is part of a move from collective to individual pay determination which makes management control over workers more effective. With individual PRP schemes, agreements tend to set a framework for individual appraisals, thus unions are unable to represent each individual worker in pay discussions. "The value of union membership might be declined because pay is determined by individual performance, rather than collective bargaining" (Heery, 1992, p.4). Kessler and Purcell (1992, p.22) argue that all the characteristics of PRP begin with cutting the power of trade unions, in the traditional collective bargaining sense, off at the knees.

Lipsey and Chrystal (1999) suggest that it is difficult and costly for management to monitor its employees' performance accurately. The effects

on motivation and desired performance will not be achieved when employees know that their better performance may not be rewarded because of a quota. Budgetary limits set by personnel departments may be a successful approach to control the costs of employees, but the staff may be de-motivated when they are recommended for bonuses but cannot get one because of budget limits (LRD, 1990, p.17). The head of the case study hospital explained to me how their nurses' pay was determined:

> "With regards to nurses' pay, their level of pay is determined by the government, the government decides how much they earn. Pay evaluation and increase for nurses take place every two years, same as doctors and other workers in the hospital. Again this follows the national pay policy for public institutions. Nurses and doctors follow same pay evaluation pattern, every two years.
>
> What does performance evaluation mean? Everyone's work is evaluated. But our performance evaluation scheme is not more than just a process. What we really evaluate is how much you contribute. How much do you contribute has a direct impact on how much you earn. Chinese people are used to the 'big bowl of rice' system (Daguofan) – yes, everyone talks about evaluation, but evaluation in China is simply to just go through the formality, no real meaning. No one really gets praised or punished as a result of the evaluation process.

So what do you do with those who are under performing? There is not much you can do to. You sack them? Downgrade them? We don't have such policy or system in place to deal with the real result of evaluation. For a public hospital like ours, most structures and policies are made by the government. But if you were to look at a private hospital in China, the boss decides it all. I understand in the west, bosses in private hospitals has got the power, even in public hospitals, the head of the hospital has a lot of say and power. But we do not have any power! There are many issues in the Chinese health system but we cannot influence that."

The Head of HR talked about what formed a nurse' pay:

"According to the government policy, pay is now made up of four parts: post pay (岗位工资), grade salary (薪级工资 sixty-five grades), performance-related pay/bonus pay (记效工资) and special allowance pay (特殊补贴 – 10% post allowance/nursing tenure allowance 岗位津贴/护龄津贴). Post pay and grade salary constitute one's 'basic pay' (岗位工资和薪级工资为基本工资).

…post pay relates to a nurse's qualification; grade salary relates to a nurse's professional job title – the government currently has sixty-five professional job title pay grades; performance-related pay is what we call bonus pay; a nurse automatically qualifies for a 10% extra government's nurse allowance pay and nurse employment age

allowance which is progressive – the longer you have been a nurse, the more you would receive in employment age allowance.

As we do not determine nurses' pay so we just follow the government's policy. But every year, nurses' grade salary pay will automatically be moved on to the next level but their basic pay remains unchanged. Basic pay is directly linked to the nurses' professional post."

The semi-structured interviews with the twelve departmental head nurses found that, six out of the twelve did not know how their pay was determined, three said they knew but could not explain, one said "I think the hospital sets out everyone's pay depending on your professional rank, education, etc…". This shows that even at managerial level, nurses at the case study hospital did not understand how they were paid, how the hospital was funded, or how the hospital determined everyone's pay. The question of "to what extent do you agree that you can disagree with the pay you are being offered" was put forward to the surveyed nurses, 293 (89%) answered. Of those, only fifteen (5%) strongly agreed, and a further forty (12%) agreed to the statement (Q14, Table 6.2). This suggests that nurses either did not speak up when they disagree with their pay, or that they were not given a choice to have a say in how their pay was determined.

This is further backed up by the response of Q15 (Table 6.2), that the majority of respondents did not feel they could talk to their line manager

about their pay either – 196 (60%) respondents disagreed that they could talk to their manager regarding pay. It is worth noting that amongst all the questions asked in the attitudes toward pay and bonus scheme section. A very small number of respondents, forty-two (13%), thought the hospital's bonus scheme was fair; 202 (61%) indicated that that the scheme was unfair (Q7, Table 6.2). This indicates that despite the hospital managers' efforts to use bonus schemes as a motivator to encourage more productivity and efficiently, nurses found the system unfair, which could lead to job dissatisfaction. So I asked the head of the hospital if he thought the nurses were being paid fairly and the reasons why. Here is what he said:

> "A nurse's basic salary is not usually very high, but in our hospital, if you combine a nurse's salary and bonus, the figure is not low. In our hospital, bonus pay on average works out higher than basic salary, this applies to most professions. In other words, the amount of bonus pay nurses generally receive is higher than their basic pay. In my personal opinion, the amount of money they receive, so basic pay plus bonus pay, compared to their contribution and their worth, is enough and at times more than what they should get. …
>
> …I believe doctors and nurses have very different roles and effects on contribution. As you can imagine, all nurses were against me! I said "what is your social value?". They all think they don't paid less under my management, but I stress the meaning of 'social value'. What do I mean by 'social value'? There are private hospitals out there, our nurses can go and apply for jobs, then the pay that private hospital

offers a nurse is in effect this nurse's 'social value'. So what the society pays you a month is how much you are worth in the society."

The head of the hospital believed nurses were paid fairly based on their contribution and their worth. He compared nurses' contribution and worth to doctors, who he himself is one. He also used social value to determine how much nurses' work are worth. This suggests that there is not a standard legal document which details the definition of contribution and worth; and that the hospital can make up its own definition and justification when determining nurses' pay. Although it is important to remember that the case study hospital is a semi-state-funded one, so the lowest basic salary is set by the central government.

The head nurse explained that the hospital used "two kinds of contracts for nurses" – permanent contract and fixed-term contract. For staff on permanent contract, "pay grades are determined by the old government policy"; the hospital followed the government policy when giving promotions and pay increases; for those on fixed-term contract, "the minimum wage is also determined by the government". This has reflected that the government does not have a set of guiding rules or structure on how fixed-term contract staff should be awarded, promoted or given salary increase. Through talking with the departmental head nurses, one of the most controversial issues was the distribution of bonus pay between permanent staff and those on fixed-term contract. According to the head of the case study hospital, the biggest

challenge for the hospital when determining both permanent and contract-based nurses' pay was:

> "…we cannot open up the gap between each pay grade. This is a common problem in China which applies to all professions. Your pay is not determined by how much you contribute. It is only reasonable to decide one's pay based on their contribution, only by doing this, people can then be motivated. If your contribution is different from mine, but we get paid the same, then this would massively dampen the enthusiasm of those who contribute a great deal. Why would they want to contribute? They don't have to bother. This is a huge problem.

In China, a nurse's length of service plays a significant role in their income. Generally, the longer the service, the higher the pay. According to official statistics, nurses working in different Chinese cities receive different levels of income accordingly. The tier system is a ranking system introduced by the Chinese central government to rank cities based on the government's development priorities. Tier 1 cities include Beijing, Shanghai, Guangzhou and Shenzhen; while Tier 2 cities include most of the provincial capitals. Nurses working Tier 1 cities earn an average of 6,700 yuan (£670) per month compared with those working Tier 2 cities who earn an average of 5,600 yuan (£560) per month (The White Paper, 2017, China). The White Paper also found in their study that most Chinese nurses highly value their 'remuneration package', among the sampled nurses, 76.5% earned less than 5,000 yuan (£500) per month, of those 37.6% received less than 3,000 yuan

(£300) per month; only 4.5% nurses received more than 8,000 yuan (£800) per month. This suggests nurses working in cities earn less than the average city income, and it is due to low pay that 48.8% nurses choose to change career (The White Paper, 2017, China).

As introduced earlier, the case study hospital employed nurses on two types of contracts – permanent and fixed-term. This is widely the case in Chinese hospitals. Studies found that different types of employment contract could lead to different pay. Among nurses earning less than 2,000 yuan (£200) per month, the majority were on fixed-term contracts and other contracts while among those earning 8,000 yuan (£800) per month, the majority were employed permanently with *bianzhi*. For those earning between 5,000 to 8,000 yuan (£500 to £800) per month, permanent contract staff made up the majority, way ahead of those on fixed-term and other contracts; and a higher percentage of nurses on fixed-term and other contracts represented the majority of those earning a monthly income of between 2,000 to 3,000 yuan (£200 to £300). Despite ongoing policy changes and call for personnel management reform in Chinese health sector to fully implement 'equal pay for equal work', it is recognised that health authorities and hospital management have not yet able to reflect fairness in nurses' pay. This continues to cause those in service feeling less valued, less satisfied, and more likely to leave the job. Workforce experts Incomes Data Services said local pay systems are not only complex and costly, they can cause resentment between staff.

6.2.1 Bonus scheme in the case study hospital

Each clinical department in the researched hospital had a bonus scheme distribution plan in place pre-defined by the hospital. According to the documentation I was given, the bonus scheme in the case study hospital aimed to strengthen financial management, minimise waste and to reduce medical cost and management consumption. The scheme was designed to establish an appropriate distribution system according to the hospital's situation; and it was also designed to break the share-and-share alike phenomena during distribution. The distribution of the bonus was based on the earnings, expenses, property and assets occupancy and medical assessment index of each clinical department, so it varied from one department to the other. This bonus scheme was to help the person in charge of each department to have a complete and thorough understanding of its earnings, expenses and surplus, so as to reduce patients' cost, meanwhile to reduce the cost of the department in order to make long-time developing plan suited to each department's conditions.

Here are the general calculation rules and principle of the bonus scheme:

Earnings－expenses＝surplus

Surplus ×distribution percentage× medical assessment index ＝bonus

Here are the distribution percentages:

1. department of internal medicine/surgical department/operation room/ department of anesthesiology /cadre's wards bonus = department's surplus × 25%

2. department of pathology/radiation department/clinical laboratory/central blood bank/department of nuclear medicine bonus = department's surplus × 18%
3. CTMR room/ultrasonic room = department's surplus × 18%

The medical assessment index includes: room rate of utilization, outpatient number, average hospitalized day, medicine earning percentage in the total earning and service quality. There are a number of forms, to check on the department which also may affect the distribution percentage, that are completed by management include: attendance, medical record quality, medical ethics and practice and service quality.

The hospital also has detailed information on the classification of earnings, and distribution of cross earnings among the clinical departments and medical technical departments:

1. Clinical departments

A. 50% of the medicine profit go to the clinical department;
B. 100% of the ward beds, nursing, treatment, special material, oxygen, heating, infant and other earnings go to clinical department;
C. 20% of the examination, radiation and laboratory examination earnings go to the department the patient is seeking advice from;
D. 10% of blood transfusion earnings go to the department the patient is seeking advice from;
E. 30% of operation earnings (including anesthesia earnings) go to the department that is doing the operation, the other 70% go to the operation room;

F. If the department has its own examination or laboratory test facilities, then 100% of those earnings go to the clinical department.

2. Medical technical departments

A. 80% of the examination, radiation, laboratory test earnings go to the medical technical departments:

B. 90% of blood transfusion earnings go to the central blood bank.

The hospital has listed the following fifteen items which are considered as the departments' costs:

1. Salary

2. Health protection cost

3. Night shift pay

4. Contracted worker salary

6. Sterilization cost, material cost (supply room)

6. Material cost (purchase & supply centre, equipment division)

7. Sterilization cost, reagent cost (pharmaceutical preparation section)

8. Business trip allowance, equipment maintenance cost, fragmentary purchase cost

9. Vehicle rental cost

10. Telephone bill

11. Furniture occupancy expenses

12. Utilities

12. House occupancy expenses

14. House decoration

16. Equipment use charge

The researched hospital earnings and its average salary/bonus/allowance cost per employee for the period between 2006 to 2010:

Table 6.1 Hospital earnings and its salary/bonus/allowance cost

	2006	2007	2008	2009	2010	Total
Hospital's Earnings	300 million	360 million	450 million	600 Million	800 million	**2.81 Billion**
Salary/ Bonus/ Allowance per employee	**21 Thousand**	**30 Thousand**	**41 Thousand**	**52 Thousand**	**64 Thousand**	

The head nurse told me that she thought the hospital's bonus scheme was 'a little messy'. She said the hospital HR department had published a guidance policy for bonus pay but it was not a compulsory policy for clinical departments to follow. In reality, departments did not implement the policy, "every department has their own bonus scheme policy and standard which is why the scheme is somewhat confusing and chaotic". The head of the hospitals said the reason behind bonus pay for nurses was simply because "doctors get bonuses so nurses get treated the same". This was not the same intension as the policy showed in terms of why nurses were paid bonuses. He said the hospital's bonus pay money came from the hospital's earnings; the government did not provide enough funding for staff salary or allowance payment, a public hospital like his was expected to "serve the public" and had to demonstrate that its ultimate interest is wa the "welfare of the general public". He explained the role between the hospital and the government when it came to serving the public:

> "…now what happens is hospitals serve the public on behalf of the government, the government controls and manages the hospital from

things like building new infrastructure or refurbishment work, buying new equipment, to paying staff members. In effect, the government buys the hospital to serve the public; but the amount of money that comes from the government is far from enough, so we are on our own, we have to bring in revenue. Part of the revenue we bring in then pays for staff's salary and bonus."

He also confirmed that every staff members' pay grade is set by the government, but the government's involvement in pay determination ends there. The government only sets the grades and the figures but does not give any money as hospitals are expected to make money to pay the staff. He said in his hospital, 'every penny is spent on staff salary, and bonus comes from the money we make ourselves'. According to the head of the case study hospital, at the time of the interview, the only fully government funded hospital in China is Zichang County Hospital. This is an experiment carried out by the central government as part of the ongoing health reform in China. The experiment is seen as a 'flagship' of the new health reform where the government pays for all costs of the hospital including infrastructure, staff pay, and equipment.

"So like our hospital, we are under direct management of the MOH, our budget comes from the Ministry. The money we have received in recent years has increased a bit, for example, last year we received just over 40,000,000 yuan (£4M), but our total revenue was

800,000,000 yuan (£80M). As I just said, the money we receive from the government has gone up a bit which we had to fight hard for. The money we receive from the government covers two main areas: special purpose funds and staff salary. For example, if you want to build a new wing for the hospital, the government usually gives you some money. This building we are in now has not fully started operating at its full capacity as we are still waiting for some equipment to be installed. The total cost of this building will be around 400,000,000 yuan (£40M), the total amount I received from the government on this building is 75,000,000 (£7.5M), which is less than 15% of my total cost. We receive a small amount of money from the government for staff salary. The money we receive from the government for staff salary works out about 2-3% of what we actually pay them. The government also pays for the retired - the money we receive for this purpose works out about 30% of what we actually pay those who are retired. So we still have to fund 70% of the retired staff salary, over 90% of the current staff salary."

But 219 (66%) respondents of the survey disagreed with the statement "given the work you are doing, you are being paid fairly" (Q1, Table 6.2); 186 (26) disagreed with the statement "the amount you are paid is fair in the context of the hospital's pay structure"; and a further sixty-three (19%) answered they did not know to this statement (Q2, Table 6.2). It once again suggests how little nurses knew about the hospital's pay level system, about pay determination, and about their rights to ask for clarification. Surveyed

nurses were keen to share information with their friends and colleagues from other departments despite the hospital's unwritten rule of "do not talk about your pay"; nonetheless, nurses were very concerned that people from other teams received higher bonus, with most of the survey nurses, 213 (65%), not satisfied with their annual pay (Q 6, Table 6.2). In the interview with the head of the hospital, I asked if he thought the nurses were happy with their pay and he said: "If you ask nurses themselves, I believe they'll say they are not happy with their pay. No one is satisfied with their pay." But he argued that the nurses should be happy with their pay:

> "If we just focus on nurses' contribution and their social value, leaving conscience aside, I think they should feel satisfied with their pay. Their pay really isn't low, especially if you compare the pay difference between doctors and nurses in the west. But the nurses will never be satisfied. If you conduct a questionnaire research on pay, I think at least 98% of the nurses will say they are not satisfied with their pay, the percentage might even be 100%.
>
> An experienced nurse here earns around 4,000-5,000rmb a month, that's basic salary plus bonus. I doubt anyone would pay that amount in other hospitals for a nurse. Although very few of the head nurses in our hospital who are extremely skilled and has years of management experience may get a job in other hospitals, but there are only a few such nurses. If two nurses are both skilled with the same experience, why would anyone pay 4000rmb when you can just pay 2000rmb? This is very nature when hospitals calculate their costs."

However, only thirty-five (10%) respondents said they their hard work was reflected in their pay (Q5, Table 6.2). This shows that nearly all surveyed nurses did not believe they were getting paid for what they did, or how much they contributed. So I asked the head nurse if she thought the nurses were happy with their pay, she said:

> "No, I do not think the contracted nurses are happy with their pay. I do not think just pay alone would affect their performance at work, at the end of the day, they need to survive, they need the job to support themselves. I understand how they would feel unbalanced/unfair."

As discussed earlier, only forty-two (13%) survey nurses thought that the hospital's bonus scheme was fair. The findings of the 10 semi-structured interviews with the departmental head nurse showed that they were all unhappy or unsatisfied with their income as well. But the reasons varied from comparing with friends in the same position in other hospitals who earned more, knowing that doctors in the same team earned a lot more, to believing that their reward simply did not match their personal contribution. Of the survey nurses, 126 (38%) responded that they agreed the hospital's current bonus scheme was extremely unfair (Q10, Table 6.2). It seemed on top of the hospital's general guidelines of bonus calculation, each clinical department had introduced their own calculation methods and rules, which worsened the entire scheme, as the majority of the nurses did not believe it was fair. All departmental head nurses explained to me during the interviews how they calculated bonus pay:

Head nurse 1:

> “Two fixed term contract nurses count as one continuing nurse when we allocate bonus every month. This is how it works: doctors first of all take their commission for each in-patient they admits monthly from the overall bonus, after that whatever is left will then be divided into two halves; we nurses take one half, and the doctors take the other half. There are fourteen nurses in my department, but only eight doctors. Each nurse will obviously get less bonus than doctors, because there are fourteen of us to share the bonus, compare to 8 of them sharing the same amount.”

Unlike the norm in Chinese hospitals where there are more doctors than nurses, head nurse 1’s department had more nurses. But bonus pay was simply divided into two halves between doctors and nurses, which separated doctors from nurses, rather than seeing them as two groups of individuals, these two groups of people were seen as two entities when it came to bonus allocation. So although more nurses may have provided efficient support and better care, the nurses had to share a smaller pot of money in exchange for more co-workers. Another unreasonable norm within the case study hospital for bonus allocation was that contract nurses were not treated equally as those on permanent contracts. As head nurse 1 explained that two fixed-term contract nurses counted as one permanent staff. This was discrimination against nurses on fixed-term contracts as they carried out the same duties and tasks. It seemed one clinical department gave the same treatment towards nurses on fixed-term contracts:

Head nurse 2:

> “Compare with a lot of other departments, my department is bit different. Doctors from other departments get commission for each patient they accept into the hospital, for operation they do, of course, now the commission for operations have been given from the central hospital budget; they also get commissions for their workload. Nurses don’t get the same treatment. But in my department, doctors don’t get any commission from our departmental income, they only receive doctors’ commission provided by the hospital. All nurses share 15% of the overall profit of, doctors share 85%. I think the bonus part is fair. No, it’s not the same. Nurses on fixed term contracts don’t get the same bonus as nurses on continuing contracts. We communicate with other departments in the hospital on this matter, HR hasn’t released any relevant documents on how much bonus fixed-term contract nurses should receive, if at all.”

This head nurses thought bonus pay was fair, even though it seemed doctors took so much more than nurses in bonus pay. According to this head nurse, the HR department had not released any guidelines on bonus allocation for fixed-term contract nurses. This shows the confusion each nurse manager operates under, which is not surprising if it provided an opportunity for non-permanent nurses to be mistreated. To add to the confusion, head nurse 3 said that their bonus was allocated and calculation by the hospital, based on a number of criterion:

Head nurse 3:

> “In my department, the way it works is that bonus is given to us by the hospital. The hospital gives my department a certain amount as bonus pay every month, which covers both doctors and nurses. The hospital used to ask us to use the ratio/calculating method provided by HR when allocating individual bonuses. Doctors and nurses use different ratio calculators. Among nurses, there are a few different ratio calculators – for example, I am now an associate professor, so I will have a higher ratio (a higher percentage) when calculating my bonus pay. For nurses in my department, their bonus pay could vary slightly depending on the number of years of service – for example, someone who’s been working in the department for five years will have a higher bonus calculation ratio than those who’s been here for three years. But I’m hoping in the future, bonus pay should be given according to job evaluation.”

Based on head nurse 3’s explanations, there seemed to be a legitimate reason behind how her department allocated bonus pay. Although it was interesting to note that she was the only interviewee hoping to link bonus pay with job evaluation. This highlights the issue that bonus pay was not awarded based on the evaluation of skills, knowledge, contributions and merit, but based on a set of pre-defined terms set by the case study hospital where they awarded those they believe deserve it. If say the hospital decided to link bonus pay with job evaluation, it could mean those who were receiving high bonus pay will no longer do so. Based on the explanation provided by eight

of the head nurses, their clinical departments followed similar methods to calculate and allocate bonus pay: each clinical department received a hospital's bonus pay ratio guideline, which included a defined professional rank for every employees, and a specific rule that gave contracted nurses entitlement to 50% of a full attendance bonus pay. At the case study hospital, bonus pay was formed of two parts: workload and attendance. The actual amount of bonus pay staff received was dependent on factors including individual's length of service, professional title, with a difference between 'formal employees' (*bianzh*i) and 'informal employees' (contract-based).

Overall, employees with longer service received more bonus pay compared to newly joined staff. Within the hospital's guideline, each clinical department was allowed to make adjustment for bonus pay allocation. For example, one of the head nurses said they used three different calculation ratios for nurses with different professional titles – a junior nurse's bonus was calculated using the lowest ratio, a higher calculation ratio was used to calculate bonus for a more senior nurse, whereas a head/chief nurse automatically qualified for the highest bonus calculation ratios of all three. Among contracted nurses, new nurses who had yet to receive professional nursing certificates receive on average 30% of what their qualified peers would earn; nurses who held the professional nursing certificates, with a service period less than two years received 40%, and those who had been with the hospital for over two years received 50%. A few of the clinical departments at the case study hospital did not take tenure into bonus pay consideration. Despite that all head nurses told me they thought the bonus calculation was complicated and it did

not necessarily reflect one's contribution, they felt that the situation was caused by hospital rules and regulations, and it was not something they could change. This means the majority of the nurses working in the case study hospital, who are contract-based, could not receive 100% bonus pay because the hospital decided to allocate bonus this way.

Table 6.2 Attitudes towards pay and bonus scheme

To what extent do you agree that…

No	Question	Attitudes towards pay and bonus scheme					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	given the work you are doing, you are being paid fairly.	2% (6)	9% (30)	12% (39)	32% (107)	34% (112)	11% (36)
2	the amount you are paid is fair in the context of the hospital's pay structure.	3% (9)	11% (35)	19% (63)	31% (102)	26% (84)	11% (37)
3	you understand how pay is decided in your hospital.	2% (8)	9% (28)	43% (143)	17% (55)	18% (59)	11% (37)
4	you are satisfied with your pay	2% (5)	12% (41)	10% (32)	36% (117)	29% (96)	12% (39)
5	your hard work is reflected in your pay.	1% (4)	9% (31)	15% (48)	38% (125)	26% (85)	11% (37)
6	you are satisfied with your annual pay rise.	2% (7)	6% (20)	8% (26)	36% (119)	36% (120)	12% (38)
7	the hospital's bonus scheme is fair.	3% (9)	10% (33)	15% (50)	31% (103)	30% (99)	11% (36)
8	your department's bonus scheme is fair.	6% (20)	20% (67)	21% (68)	20% (65)	22% (73)	11% (37)
9	your department's bonus scheme is open.	13% (43)	32% (105)	16% (54)	12% (41)	14% (47)	12% (40)
10	the current bonus scheme is extremely unfair.	15% (49)	23% (77)	20% (66)	17% (56)	13% (44)	12% (38)
11	the harder you work, the more bonus you receive.	3% (11)	14% (47)	16% (53)	32% (105)	22% (74)	12% (40)
12	you receive various benefits and allowance during holidays and festivals.	10% (32)	36% (118)	12% (41)	16% (54)	14% (47)	12% (38)
13	you have a frugal lifestyle because your pay is low.	25% (81)	40% (131)	10% (34)	10% (34)	4% (12)	12% (38)
14	you can disagree with the pay you are being offered.	5% (15)	12% (40)	25% (83)	28% (93)	19% (62)	11% (37)
15	you can talk to your line manager about your pay.	3% (10)	8% (27)	17% (57)	31% (102)	29% (94)	12% (40)

It was somewhat shocking for me to hear the head nurses saying that they treated contract-based nurses differently even though “there is no difference in work responsibilities between permanent staff and contract-based nurses”. Given the hospital’s head nurse said most nurses were recruited on fixed-term contracts, this shows that most nurses working in the case study hospital were not being paid equally for what they do. Only head nurse 5’s clinical department treated their nurses in the same way: “We have a 30/70 ratio – 30% of the overall bonus pay is allocated depending on your professional title and your continuity of employment; 70% is shared equally amongst everyone. I think it’s pretty fair (Head nurse 5).”

All twelve of the departmental head nurses did not think the bonus scheme could motivate workers to work harder; on the contrary, it had caused problems. Departmental head nurse 1 explained:

> “Doctors have more grey income, but nurses hardly get any grey income. This is due to the hospital’s policies – national medical insurance that most patients use are subject to an excess, this means all patients are trying go over the excess amount, in order to get some money back. Doctors get commission for drugs they subscribe, they get commission for the medical apparatus they use. Our overall income per month gets deducted if we go over the excess, which means there’s less money for the bonus. But doctors don’t mind so much, as when they are subscribing drugs, they get commission. Our workload has increased a lot due to the number of drugs that are subscribed, as we have to keep all records of all the drugs used by

every patient every day, but our income has dropped. So I don't think this policy is fair for nurses."

Departmental head nurse 5 echoed similar concerns: "…a junior doctor who just started work has the same ratio/percentage as a nurse who's been working for over twenty years. That is unfair."

The hospital employed 1,153 nurses in total, of whom only 326 were permanent staff, which meant about 71% of the nurses were on fixed-term contracts. Both the head nurse and the head of the hospital said that nurses on fixed-term contracts were either not eligible for bonus pay, or did not receive the same amount as permanent staff. A few departmental head nurses said the different treatment towards bonus pay for permanent and fixed-term contract staff was causing problems. Departmental head nurse 3 said:

"No, I don't think it can encourage nurses to work harder. It also causes issues like: a younger nurse who takes on a lot of responsibilities and work very hard doesn't necessarily get the right amount of bonus to reflect their workload, due to the ratio calculator system the hospital has imposed on us; so in this situation, an older nurse who doesn't do as much will still get more bonus pay. Again, this is why I really want to do something about the way we calculate bonus pay."

Departmental head nurse 8 said: "…a fixed term contract nurse who has a long service history is earning less than those on continuing contracts, this makes them think the bonus scheme is unfair."

Departmental head nurse 9 said: "For contracted nurses, those who have been here longer don't necessarily work harder than those who are less experienced and earn less. …contracted staff want to be treated equally as permanent staff when calculating bonus pay."

In earlier discussions over nurses' attitudes towards the researched hospital's bonus scheme, respondents largely gave a negative answer when asked if they were satisfied with their pay (213, 65%). As mentioned before, nurses on fixed-term contracts carried out exactly the same responsibilities as those on permanent contract, however unequal pay and benefits, in this case, lower or lack of bonus pay for contracted nurses will raise concerns about equity and job dissatisfaction (Shang *et al.*, 2014). This corresponds with findings from other studies that have shown evidence that nurses' job dissatisfaction can be linked to poor patient care and high job turnover (Liu *et al.*, 2012; Tennant, 2015). Also, as a result of low pay for contracted nurses, the survey found that 212 (65%) respondents lived a frugal lifestyle because of their low pay (Q13, Table 6.2).

6.2.2 Nurses' knowledge about pay and the bonus scheme

The first part of my twelve interviews with the departmental head nurses was to find out their knowledge towards their pay and the bonus scheme. Five

departmental head nurses said they more or less knew how their basic pay was determined, the other seven did not know who determines or how their basic pay was determined. When asked if they were happy with their basic pay, all twelves said “No.” According to the twelve head nurses’ answers, most of them on average earned RMB2,000 per calendar month, which is about £200. The highest earning departmental head nurse interviewed receive about RMB2,450 (£245) per month and the lowest earning head nurse receive about RMB1,700 (£170). All the head nurses received bonus pay, ranging from RMB1,000 (£100) to over RMB3,000 (£300) per calendar month. Not everyone was satisfied with their bonus pay.

It appeared that every clinical department had their own bonus pay calculation policy, a system which was adapted based on the hospital bonus allocation to them. All twelve departmental head nurses understood how their own bonus was calculated, but had all express unhappiness towards the scheme. The twelve nurses I interviewed said that they work very hard and that they were trying their own very best to contribute to the hospital, but neither the basic pay or the bonus pay reflected the amount of hard work they put in. The head of the hospital shared similar views:

> “Everyone has desires, it’s impossible to satisfy people’s desires all the time. Nurses’ contribution varies – pay doesn’t always reflect the difference in their contribution; sometimes those who contribute less may get higher pay, because they have longer service history and are of seniority. So those who are on lower professional ranks but contribute more doesn’t always get more pay.

> This sort of phenomenon is widely seen in most public sector organisations. We emphasis on contribution because we want contribution to match people's earnings and the hospital's profit. But we can't quite do that now."

One thing worth noticing is that all the departmental head nurses I interviewed were on continuing contracts. Almost all the head nurses said their clinical departments treated permanent and contract-based nurses differently when it came to bonus pay, and all twelve nurses expressed concerns with how bonus pay was calculated internally, and that they were fully aware that contract-based nurses were extremely unhappy with their bonus pay. The head nurse's knowledge towards the bonus scheme was more detailed. She pointed out that the NMW set for nurses was simply too low, so the bonus scheme was a way to make up for the low basic pay, and the whole country followed this method.

In the case study hospital, all nurses on permanent contracts were eligible for the bonus scheme, only some nurses on fixed-term contracts were eligible for the bonus scheme, this varied depending on the actual clinical department they were in. The head nurse explained that everyone needed to be evaluated mainly against attendance, experience and performance for the purpose of bonus pay allocation; she had previously suggested HR to draft a new standardised level of bonus payment for the contract-based nurses. She understood how the distribution percentage and the medical assessment index were calculated for different clinical department, and that she believed

that all nurses should understand it too. The head of HR said the HR department had sent out relevant documents to each department, so everyone should know how this scheme works. Management expected employees to find out and to learn about the scheme, whereas most of the employees said they had never seen the documents. Employees did not doubt that the documents existed, but most of them thought, whether or not they agreed with the scheme, was not going to change how much they receive, therefore it was pointless to even bother learning about it.

"The most important aspect to nurses' job satisfaction is pay, followed by staffing and benefit" (Sparks *et al.*, 2005, p.922). As the head nurse pointed out again that the current bonus scheme was to motivate nurses to work harder and contribute more to the hospital. However, so far the scheme did not appear to be motivating enough. She explained that the cause of this was because the way the bonus was calculated did not involve nurses' individual performance, all nurses in the same department received pretty much the same bonus, no matter how hard you worked. It was not a case of the harder you worked, the more you got. She also said it was slightly easier to see the differences between each clinical department, if one department earned more, then nurses working there were more likely to receive higher bonus.

The head nurse did not see any connection between the bonus scheme and the quantity and quality of work done. She explained that if more patients came to the hospital, workload would go up, so the bonus would go as well,

but the quality of the work done by the nurses had not changed because of the bonus scheme. Nurses would still do what they should do, and the only change would be that that they would be more willing to receive more patients in order to raise workload, to ultimately receive a higher bonus. This , however, instead of improving the quality of work, she has noticed that if more patients were admitted, nurses needed to work harder and longer hours to treat them, and the quality of work actually went down, which meant that if mistakes were made, and their bonus would be deducted. The head nurse believed that all departments were willing to receive as many patients as they possibly could handle within their staffing capacity, and at the same time were trying to avoid any accidents or mistakes. Out of the twelve departmental head nurses I interviewed, eight of them did not think the bonus scheme could motivate nurses to work harder, two thought the scheme could motivate nurses, one believed it more or less served its purposes, one thought it only motivated the nurses a little. Two out of the twelve departmental head nurses did not think the bonus scheme had caused any problems among the workers, whilst the other ten said the scheme was causing too many issues. Two of the most concerning issues were the different levels of bonus pay between nurses on permanent contracts and those on fixed-term contracts, and the bonus pay difference between doctors and nurses.

A few departmental head nurses expressed that the way bonus scheme operated could be very unfair – for examples, a contract-based nurse who had exactly the same experience, same qualification, same length of service,

same responsibility, same contribution and same performance as a nurse on permanent contract, received a much smaller bonus payment. One head nurse told me that in some cases, a contract-based nurse who had a longer service history was earning less than those who had shorter service history, but on continuing contracts. This had made the contract-based nurses believe the bonus scheme was extremely unfair. Another head nurse said her staff who were on fixed-term contracted wanted to be treated equally as permanent staff when it came to bonus pay. The head of HR did suggest that contract-based nurses could eventually be receiving the same amount of bonus pay as those on permanent contracts:

> "Since 2007, we have hardly recruited any nurse on permanent contract; nearly all of the nurses we have recruited are contract-based nurses. This is a pan university requirement – unless the candidate holds a doctorate degree or above, no permanent contract would be given. Contract-based nurses and permanent staff receive similar bonus pay; the hospital provides a guidance to each department, for example, usually, a newly recruited contract-based nurse would receive 50% of the what a permanent contract nurse receives monthly in bonus pay, but with the increase of their service history, the development in professional skills and the experience they gain, their performance and personal achievement will be evaluated, after which a contract-based nurse could eventually receive 100% bonus pay, same as a permanent post holder."

Doctors' bonus pay calculation has also led the nurses to believe that they were being treated unfairly. One of the departmental head nurses who had been doing her job for over twenty years told me:

> "the bonus scheme has caused problems, but these are problems we cannot solve ourselves. Doctors have more grey income, but nurses hardly get any grey income. This is due to the hospital's policies – national medical insurance that most patients use are subject to an excess, this means all patients are trying to go over the excess amount in order to claim money back. Doctors get commission for drugs they subscribe, they also receive commission for the medical apparatus they use. Our overall income per month gets deducted if we go over the insurance excess the hospital set out for us, which means ultimately there's less money for bonus pay. However, doctors don't mind so much as every time they subscribe drugs, they get commission. Our workload has increased a lot due to the number of drugs used by every patient every day, but our income has dropped. So, I don't think this policy is fair for nurse".

Another head nurse told me that a junior doctor who has just started working in the hospital earned the same percentage bonus as a nurse with over twenty years' service history, and that was unfair. Bonus pay money at the case study hospital was centrally managed. Each month, the finance department informed each department the total amount they would receive from the hospital for bonus pay. The number varied from month to month,

largely affected by the hospital's overall income and spending. The head of HR explained the two-tiered bonus pay allocation process:

> "About 25% of the hospital's total income is used for employee bonus pay. Each month, the hospital will give each department a figure, the department will then use their own bonus scheme ratio to calculation how much each person receives. So there is a second tier bonus pay allocation. The first tier is from the hospital to each department, the second tier is from each department to the employee.
>
> For the nurses, the ratio between salary and bonus pay is around 1:1, some would receive a higher bonus pay than basic salary."

Management sees bonus as a way to motivate workers to work harder so as to increase productivity and efficiency at work, however, not every bonus scheme is as effective as management had hoped. This is due to issues over the unfairness and inappropriateness allocation of bonus payment may create further tension and conflict between employers and its staff.

6.3 Nurses' attitudes towards job evaluation

Job evaluation is a method of establishing the relative position of jobs in a job hierarchy, and attempts to measure the relative value of each job (ACAS, 2014). It does not evaluate people, it does not determine pay, but it provides a measure of the relative merit of different jobs. It compares different jobs within an organisation or an industry, and then ranks them in an order which may be used to determine relative rates of pay. There are two types of job

evaluation schemes: analytical scheme, where jobs are divided into individual components, every one of which is assessed and raked separately, and non-analytical assess the job as a whole. According to IRS (IRS Employment Review, 2004), 86% of the 162 employing organisations use analytical schemes, they believe analytical schemes can improve objectivity in valuing jobs and can help employers against equal pay claims. The case study hospital had a set of rules and standards to evaluation nurses' work. The hospital head nurse introduced what they called a "three-tier quality control and management" job evaluation process, she explained:

> "..the departmental head nurse needs to conduct a monthly quality control evaluation. Nurses' performance is monitored and managed on a daily basis by the head nurse, it's part of a head nurse's daily job. The difficulty comes when some head nurses lack responsibility and ability. Some are not responsible, some have fewer skills, so a head nurse's personal ability does make managing performance difficult."

When I asked the head of the hospital about how the hospital was managed he used the difficulty in job evaluation as an example to answer my question:

> "All of the new nurses we recruit now are on fixed-term contracts which basically means they are easy to manage. In the past, everyone was recruited on a formal continuing basis which means you can't sack them. So if a nurse under-performs, we don't renew his/her contract. But this proves to be difficult. Let me explain.

> Every nurse in our hospital has to take an annual skills test as well as an annual evaluation; we also periodically ask the patients to fill out 'satisfactory questionnaire' to tell us how they think the nurses are performing – at the end of all this, I would see thirty to fifty nurses to not have reached the expected performance level so their contracts would not be renewed. In effect, those who do not reach our standards will lose their job.
>
> However, what happens is, when the final annual performance result of each nurse is announced, an old hospital employee who has worked for the hospital for thirty or forth years comes to me and says one of the nurses you are about to sack is my relative, my niece, my daughter, etc., please do not let her go. So what do I do now? Do I sack her? The answer is no, I cannot let her go.
>
> I have taken management course, I know how to manage, I know the correct way to manage, but these methods, principles and rules will not get you anywhere here. It is not because people do not know the right ways of doing things – everyone knows how to manage successfully, such rules and methods have to be implemented, but you cannot do it here, not in this environment. Should you dare to try, you will fail and you will be hurt badly. This simply cannot be done!"

This suggests how Chinese culture and tradition not only affect but hinder real job evaluation process from taking place in public-owned enterprises. As

discussed in the earlier literature, caused by the legacy policy enforced by the government, Chinese public-sector organisations cannot really manage low performance, cannot lay off workers even if they were negligent, absent or indolent at work (Child, 1994). This links directly to staff low motivation, and declining organisational performance (Warner, 1995; Frear 2012).

Table 6.3 Attitudes towards job evaluation

To what extent do you agree that…

No	Question	Attitudes towards job evaluation					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	the hospital's appraisal policy is fair and transparent.	3% (9)	18% (60)	33% (109)	16% (51)	20% (66)	11% (35)
2	the hospital has a clear, fair and reasonable promotion policy.	2% (7)	19% (63)	28% (92)	19% (62)	22% (71)	11% (35)
3	promotion opportunities in the hospital are fair and reasonable.	2% (5)	18% (59)	30% (99)	18% (60)	22% (72)	11% (35)
4	being promoted in the hospital is difficult.	22% (72)	37% (122)	19% (63)	5% (16)	6% (20)	11% (37)
5	it's very competitive to get promoted in the hospital.	28% (91)	37% (123)	14% (47)	6% (18)	4% (13)	12% (38)
6	you have been promoted during the last 3 years.	3% (9)	9% (29)	15% (50)	32% (107)	29% (95)	12% (40)
7	your line manager (the person who does your job evaluation and appraisal) is very familiar with your work.	7% (24)	38% (125)	26% (84)	10% (32)	8% (27)	12% (38)
8	you are given a chance to speak up in your job evaluation/appraisal.	3% (9)	22% (71)	28% (91)	21% (68)	16% (52)	12% (39)
9	your line manager (the person who does your job evaluation and appraisal) usually discusses the details with you about your appraisal.	4% (14)	24% (79)	22% (74)	25% (83)	13% (43)	11% (37)
10	your job evaluation decides how much you earn.	8% (25)	20% (67)	31% (103)	16% (51)	14% (46)	12% (38)

The questions raised in this section about nurses attitudes towards job evaluation showed that the majority of the nurses did not think the hospital's appraisal policy was fair or transparent, and that the vast majority of the respondents agreed that it was difficult to be promoted and this is further

proved by the number of respondents who agreed to the question that they have been promoted once during the past three years.

A shocking 103 (31%) respondents said they did not know if their job evaluation decided how much they earned (Q10, Table 4.6). Only eighty (24%) out of 291 who answered the question said that they were given a chance to speak up in the job evaluation, appraisal process (Q8, Table 6.3). This suggests the definition of job evaluation and its process in the case study hospital seemed blurred. It had not served the purpose of reviewing one's work and setting objectives. It also appeared that all departmental head nurse had responsibility to conduct regular job evaluation with the nurses they managed; different forms of evaluation took place on a daily and monthly basis. Departmental head nurse 3 gave a very detailed example of how she evaluated and managed nurses' daily performance:

> "I have a series of quality control standards – I check on all the nurses' performance on a regular and ad–hoc basis; one of the most straight forward ways of monitoring performance is to check on the implementation of doctors' orders for patients. For example, in recent years, patients are subscribed bottles of drip every day, in some extreme cases, one patient has to go through 20-30 bottles of drip in a day; so if nurses manage to make sure that all the patients go through all there drip orders every day, it's a lot of work done by the nurses already. But I feel sometimes our nurses really are very busy and I don't want to take up their time."

6.4 Nurses' attitudes towards training and development

In the jointly released White Paper (2017) by the China Social Welfare Foundation, the Nurse Caring Plan and other groups, only 58.6% nurses in the study said that their employer offered professional training and career development opportunities. Nurses of this study said they would like to have more training opportunities, out of the 235 (71%) of the respondents who would like to have more training opportunities (Q6, Table 6.4), 233 (71%) also agreed that they needed regular training to improve nursing skills (Q9, Table 6.4). Out of the 293 (89%) respondents who answered the question if they were aware of their personal development opportunities and direction; only 108 (32%) respondents said they were aware, 112 (34%) said they did not know (Q15, Table 6.4). Over half of respondents, 151 (46%) out of 290 (88%) who answered the question Q7 (Table 6.4) said their line manager decided what training they had. Training is recognised as a need for nurses to improve their skills, however findings show that nurse managers decide the training and the skills needed, which means that allowing nurses' to seek development in the area they are interested in can be tricky.

In my previous research (Feng, 2007), one of the nurses who spoke up about her intention to leave work said the people who worked harder were never awarded, but those who did not work hard and made mistakes were never punished. She found it very difficult to be valued no matter how much she contributed to the department and the hospital, and she believed that many of her colleagues felt the same way, and the only reason why she was leaving work was because she was still young, single and had enough

money to survive. While other colleagues of hers were married with children and had more family responsibilities, so could not afford to leave their jobs.

Table 6.4 Attitudes towards training and development

To what extent do you agree that…

No	Question	Attitudes towards job evaluation					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	the hospital provides you with regular professional nursing training opportunities.	7% (23)	37% (122)	12% (38)	19% (61)	15% (50)	11% (36)
2	you have training opportunities every year.	5% (17)	28% (91)	12% (40)	26% (86)	18% (59)	11% (37)
3	you have attended at least one training course during the last 3 years.	12% (40)	42% (137)	8% (25)	14% (46)	14% (46)	11% (36)
4	the training course you have been on is very helpful for your work.	9% (30)	39% (130)	14% (46)	16% (54)	9% (29)	12% (41)
5	you can ask your line manager if you want to go on a particular training course.	6% (21)	25% (83)	24% (80)	25% (81)	9% (28)	11% (37)
6	you would like to have more training opportunities.	27% (90)	44% (145)	9% (30)	5% (17)	3% (10)	12% (38)
7	your line manager decides what training you should have.	10% (33)	36% (118)	24% (80)	14% (47)	4% (12)	12% (40)
8	all training opportunities in your department are allocated by your line manager.	20% (66)	37% (123)	19% (64)	9% (30)	2% (7)	12% (40)
9	you feel that you need regular training to improve your nursing skills.	23% (75)	48% (158)	13% (42)	4% (13)	2% (5)	11% (37)
10	your colleagues have many training opportunities.	3% (11)	16% (53)	33% (110)	26% (85)	9% (31)	12% (40)
11	training opportunities are always given to colleagues who have a closer relationship with the boss.	13% (43)	19% (62)	36% (118)	17% (57)	3% (9)	12% (41)
12	there is a dedicated person who gives your advice on career development.	2% (6)	19% (64)	22% (74)	29% (94)	16% (52)	12% (40)
13	you have made progress in your work skills and gained more experience during the last year.	14% (47)	44% (146)	19% (63)	8% (27)	3% (10)	11% (37)
14	the training opportunities you have been provided with have helped your life greatly.	8% (26)	29% (95)	23% (77)	22% (72)	7% (23)	11% (37)
15	you are fully aware of your personal development opportunities and direction.	7% (23)	26% (85)	34% (112)	16% (51)	7% (22)	11% (37)

Nurses in China felt they have less access to training opportunities than nurses in the West (Laschinger *et al.*, 2006). Sun (2009) suggested this is due to the nature of the tasks nurses in western countries are expected to carry out, which means that they must attend courses to improve their professional knowledge. But in China nurses have very limited access to gaining more knowledge and to communicate with peers.

6.5 Nurses' attitudes towards career development

Larger number of respondents answered negatively towards the question "Do you agree you have full confidence in your career development?" 135 (41%) disagreed with the statement; only seventy-nine (23%) agreed (Q4, Table 6.5). This suggests that nurses participating in this study were not clear where their career was going, and this finding adds to the existing evidence that in China, nurses receive little career guidance with most nurses being unsure about their career development and employers seldom have supporting policies (Yang *et al.*, 2017). What is more crucial is that people's understanding of nursing as an occupation is that it does not require technical skills and, therefore, should receive low pay (Zeng, 2009).

Compared with the number of respondents who did not have confidence in their career development, more respondents, 140 respondents (42%) did not think that working in the hospital was very beneficial for their personal development (Q 5, Table 6.5) with only 116 (35%) of respondents believing that career development opportunities were always given to people who were the most suitable (Q13, Table 6.5)

Table 6.5 Attitudes towards career development

To what extent do you agree that…

No	Question	Attitudes towards career development					
		Strongly agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1	Void 6
1	you are interested in what you do and it's suitable for you.	13% (43)	31% (103)	21% (68)	17% (56)	7% (24)	11%(36)
2	you will choose to be a nurse again given the chance.	6% (20)	12% (41)	15% (50)	27% (89)	29% (95)	11%(35)
3	being a nurse is your ideal job.	5% (15)	16% (53)	13% (42)	34% (113)	22% (72)	11%(35)
4	you have full confidence in your career development.	6% (18)	19% (61)	24% (78)	23% (76)	18% (59)	12% (38)
5	working in your hospital is very beneficial for your personal development.	6% (18)	18% (60)	22% (74)	26% (85)	17% (55)	12% (38)
6	you hope you can carry on working in your department and in the hospital.	12% (38)	32% (107)	22% (71)	14% (46)	9% (30)	12% (38)
7	you have thought about leaving the hospital.	7% (23)	24% (78)	21% (70)	26% (86)	11% (36)	11%(37)
8	you really want to leave the hospital.	4% (12)	11% (37)	26% (86)	30% (99)	17% (57)	12%(39)
9	your job gives you plenty of security.	6% (21)	22% (71)	22% (74)	25% (83)	13% (43)	12%(38)
10	you are worried that you'll lose your job.	7% (24)	14% (47)	33% (109)	25% (82)	9% (30)	12%(38)
11	you are fed up with your job, so you want to change your career.	5% (15)	15% (50)	25% (82)	30% (98)	15% (49)	11% (36)
12	you often speak to people about your work stress and trouble.	9% (29)	35% (116)	13% (44)	26% (85)	6% (19)	11% (37)
13	career development opportunities are always given to people who are the most suitable.	6% (20)	29% (96)	27% (90)	15% (49)	11% (36)	12% (39)
14	career development opportunities are always given to people who have a closer relationship with the boss.	17% (57)	29% (94)	31% (101)	9% (29)	4% (12)	11%(37)
15	your family understands and supports what you do.	22% (73)	46% (153)	11% (35)	7% (23)	3% (9)	11% (37)
16	work is a small part of your life.	7% (24)	31% (101)	15% (48)	27% (90)	9% (29)	12% (38)
17	your life is all about work.	4% (14)	21% (69)	14% (47)	39% (127)	11% (36)	11% (37)
18	you can leave your job anytime.	6% (19)	16% (53)	28% (92)	29% (97)	10% (33)	11% (36)

19	you are completely devoted to your current job.	21% (68)	52% (172)	10% (33)	5% (17)	1% (4)	11% (36)
20	there's a big conflict between your job and your personal life.	14% (45)	39% (129)	18% (60)	16% (52)	2% (8)	11% (36)

However, 151 (46%) agreed to the statement "career development opportunities are always given to people who have a closer relationship with the boss". It is worth pointing out that 101 (31%) respondents answered "do not know" to this question. This is indicative that the underlying conflict and dissatisfaction between nurses and nurse managers, in the way managers manage and behave.

101 (31%) respondents had thought about leaving the hospital (Q7, Table 6.5); and 49 (15%) respondents indicated that they really wanted to leave the hospital. These figures were higher than findings of Zhang *et al.*'s study but in line with others including Aiken *et al.* (2002), Xun and Wu (2011). Only seventy-two (22%) respondents said they could leave their job any time (Q18, Table 6.5), sixty-five (20%) respondents said they were fed up with their job so wanted to change career (Q11, Table 6.5) with over half of the respondents said they would not choose to be a nurse again if given the chance (Q2, Table 6.5). The majority of the respondents hoped they could carry on working in the department, as well as in the hospital (Q6, Table 6.5). According to the 2017 White Paper nearly 50% of sampled nurses either said "no" or "not sure yet" to the question "Would you continue choosing nursing as your career?", with around 47% nurses planning to change their career between age thirty to forty, and this further proves that those who are in nursing jobs between six to ten years are most likely to quit. Furthermore,

this research finds that 174 (53%) respondents indicated that there was a big conflict between their job and their personal life (Q20, Table 6.5). This could have been caused by a number of factors including work-related stress, time spent at work and the impossibility of leaving the job; but only less than half of the respondents, 145 (44%), often spoke to people about their work stress and trouble (Q12, Table 6.5).

6.6 Conclusion

This chapter has tested the hypotheses on the nature of the work situation, including contracts and pay determination, pay and bonus scheme; and the nature of the profession and changes in terms of training and career development, as the relevant factors of Chinese public sector nurses' attitudes to and at work.

Pay is the main issue in the exchange between employers and employees, which reflects the connection between an individual's work and the performance of the employing organisation itself (Hegewisch, 1991). It has become clear from the findings that nurses at the researched hospital were most concerned with their pay. The difference in pay between permanent contract nurses and contract-based nurses was the major cause for job dissatisfaction, higher turnover among contract-based nurses and motivation. Job dissatisfaction has been associated negatively with quality of care.

The central government's personnel recruitment control over public sector organisations meant that the hospital management had no choice but to offer contract-based nurses poorer terms and conditions of service with fewer

employment benefits. Over 70% of (827) nurses working at the case study hospital were on fixed-term contracts. Nurses on these contracts were treated differently from those on a permanent contract. It became clear that the existence of the different types of contracts has caused tension between nurses, nurses and management, and nurses and the hospital authorities.

All head nurses interviewed were not happy with their basic salary. Seven out of the twelve interviewed head nurses did not know how their basic pay or their nurses' basic pay were determined. But all of them understood how bonus pay was calculated, and that they participated in their team's bonus pay calculation. Head nurses voiced concerns over the hospital's bonus scheme seeing it as not motivating enough because it was not related to individual performance. There was no real connection between the bonus scheme and the quantity and quality of work done, because if more patients came to the hospital, workload would go up, along up the bonus; but the quality of the work done by the nurses had not changed, nurses would still do what they should do without more support. The only change would be that that they would be more willing to receive more patients in order to raise workload, to ultimately receive a higher bonus; and thereby patient care quality could be compromised. Unfair calculation of bonus pay between a contract-based nurse who has exactly the same experience, same qualification, same years of service, same responsibility, same contribution and same performance compared to a nurse on permanent contract, mean that they received a much smaller bonus pay. The case study hospital bonus pay allocation also seemed to discriminate nurses against doctors.

Job evaluation at the case study hospital could not be carried out properly as pressure from the Chinese society, its culture and tradition hinder real job evaluation processes from taking place in public-owned enterprises, and that nurses did not feel they were given a fair and transparent job evaluation. Three quarters of the respondents in this study said they would like to and needed more training opportunities. Only a third of respondents were aware of training opportunities and nearly all said their managers decided the training they were given and the skills needed for their jobs. Only a quarter of the respondents felt confident about their career development. Nurses participated in this study were not clear with where their career was going, and this finding adds to the existing evidence that in China, nurses receive little career guidance (Yang *et al.*, 2017). What is more alarming is that people's understanding of nursing as an occupation is that it does not require technical skills and, therefore, should receive low pay (Zeng, 2009).

Chapter Seven

Further discussion and conclusion

This thesis is a case study looking at Chinese nurses' attitudes to and at work based on Goldthorpe's model when he looked at the relationship of car workers to their working lives.

This research was based on Goldthorpe's study of car workers' attitudes to their working lives in which they studied the relationship between the worker and the job; the worker and the work group; and the worker and the firm, it assessed nurses' relationship with others, including patients, co-workers and management. Goldthorpe found that regardless of the car workers' affluent condition, they were still "wage-workers, engaged in selling their labour power in a market situation" (1968, p.147), and just like any other worker who seek to satisfy in their work not only economic needs but also needs of a 'social' kind. Workers stressed the importance of social relationships in general, not only between co-workers, but between workers and supervisors and workers and management, as a crucial determinant of work attitudes and behaviour. Findings from this study echoed these tendencies and showed that nurses too, seek acceptance, approval, recognition, status, and so on, but have little control over pay, management of pay, and their career development, which ultimately means they are just paid workers that are subject to management control and other terms and conditions of their work. Nurses in this study supported their co-workers, but they believed management is hierarchical, and view their work conditions as irrational.

Management control and the general terms and conditions of nurses' work affect their job satisfaction, although as Goldthorpe reiterated, it is difficult to assess the degree of workers' satisfaction with their jobs, because "a man's work tends to be a more important determinant of his self-image than most other of his social activities" (Goldthorpe, 1968, p.11). Thus, workers do not like to admit they dislike their job without compromising self-respect. However, by the fact that workers choose to remain in particular jobs does show some degree of satisfaction with them, relative to other jobs that are available in the market. Another factor which contributes to job satisfaction is the pace of work for car workers. Although finding the pace of work too fast was not closely associated with monotony, workers who work at an excessive pace, such as the nurses in this study who did not have enough time to treat patients and were constantly put under pressure, would feel dissatisfaction, and both psychological or physical stresses.

Parallel to Goldthorpe's concept of professionalism, nurses' choice to remain in a particular job shows some degree of satisfaction with it, relative to other jobs that are available in the market. But like the car workers, nurses were motivated to increase their economic returns from work which gave them the ability to support family and the power as consumers. Car workers viewed high income as the overriding factor that determined job choice or attachment, "considerations relating to the nature of work-tasks, working conditions, workmates and superiors are generally of at least comparable importance" (Goldthorpe, 1968, p.148). This also applies to the relationship between workers and their employer. More rewarding and less stressful jobs

did not guarantee workers' appreciation and attachment towards an organisation.

Most resentment towards management and the job were caused or closely related to the dissatisfaction in both pay and bonus pay nurses received. Like workers in Goldthorpe's study, most nurses did not feel they could achieve any promotion or saw clear career development opportunities which could mean more pay, and would consider leaving their job for a better paid one. For those who were in the jobs because the level of pay, regardless of how close they are to their co-workers, they would be prepared to leave them for jobs that are better paid.

As Goldthorpe stresses:

> "this entire theoretical position must of course depend for its validity upon the extent to which, in Woodward's formulation, 'industrial behaviour at all levels is a function of the work situation itself', in other words upon the extent to which employers' performance and experience of their technologically determined work-tasks and –roles is correlated with the ways in which they are disposed to act towards their mates, their superiors, their employer, etc. And in this respect, the main significance of the findings presented in this study is to indicate that no such correlations need exist." (1968, p.181).

Despite the various reforms China has undergone since the 1980s, along with the economic restructuring and transformation of social services,

straight-forward requirements such as nurse-to-bed ratio standards was not met at the case study hospital. The case study hospital management said that the reason for not meeting the standard was purely cost related – the hospital would need to recruit an extra one hundred full-time nurses and an extra one hundred care workers. To make this happen, the case study hospital would either need to receive more funding from the government or to increase its service fees, but neither of which was agreed by the central government, even though the Chinese government had introduced different market and managerial strategies to decentralise health planning and financing functions, with the hope of introducing profit-making incentives and to promote diversified services (Wong and Chiu 1997).

Decentralisation and the introduction of market forces were adopted to help improve service performance and to reduce budget pressure for the Chinese government (Liu, 2004). The purpose was to increase competition as well as to expand healthcare coverage, with basic medical care being provided by public hospitals whilst special services offered by profit-driven enterprises. The government subsidies part of the personnel wages and some new facility investments while hospitals are encouraged to increase their income and to improve efficiency. The case study hospital was only partly funded by the government and that the funding the hospital received from the government was meant to cover two main areas: special purpose funds and staff salary. But according to the head of the hospital, the actual amount of funding the hospital received year on year was far from enough to meet neither one of those purposes. It was claimed by the head of the hospital that

the allocation of the funding and the level of funding received by hospitals around the country did not follow any strict rules, and there were only a handful of hospitals that were fully funded by the government out of nearly 20,000 Chinese public hospitals.

The overall Chinese health service is under-funded by the government and the distribution of health resources is unbalanced among different regions (Liu, 2004; Tao *et al.*, 2012; Yang, 2013). The government does not appear to have a consistent investment strategy. It might seem that the total health expenditure as a percentage of GDP has increased but the government's spending as a share of the total health expenditure has decreased over the years. This has led to dramatic institutional changes in Chinese hospitals and means that hospitals have to find ways to generate revenue to pay for facilities, expansion, staff salary and so on. During the more open conversations I held with a few of the head nurses at the case study hospital, they explained how both the hospital and the doctors had been relying on prescribing 'more than necessity' amount of medication to patients to generate 'grey income' for doctors and profits for the hospital (Cao, 2015). As many have discussed, public hospitals that are massively under-funded would end up seeking possible alternatives in order to pay its employees (Hillier and Shen, 1995; Liu, 2004; DeNoble, 2012).

In 2012, The Chinese Ministry of Health reported that the number of registered nurse has reached 3.49 million, which equals about 1.85 nurses per 1,000 population in both urban and rural China, compared to 8.2 nurses

per 1000 population in the UK (OECD, 2014). Out of the 1.83 million nurses working in hospitals in China, the vast majority work in public sector hospitals (MOH, 2012). One of the key issues found in this research is the resentment caused by the different types of employment contracts the hospital uses between those who are within '*bianzhi'*, also known as permanent staff, and those who are not. The use of fixed-term contracts became popular in China when the open-up policy was implemented in the 1980s and was later spread to all hospitals in the country. This is widely the case in Chinese hospitals that nurses are put on only two types of contracts – permanent or fixed-term. Contracted nurses at the case study hospital claimed that they worked harder than those with permanent contracts but did not receive more pay or given more career development opportunities. The same unfair treatment was seen in the case study hospital's bonus scheme which featured a two-tiered bonus allocation process.

The vast majority of nurses in this study did not know how their basic pay was determined. It seemed in Chinese public sector hospitals staff on permanent contract received their basic pay based on an old government policy which determined nurses' pay grades and pay range. Hospitals mostly paid contracted nurses minimum wage determined by the government. The government does not have a set of guiding rules or structure on how fixed-term contract staff should be awarded, promoted or given salary progression increase. Management team in the case study hospital believed nurses were paid fairly based on their contribution and their worth. There was not a standard legal document which detailed the definition of contribution and

worth; and that the hospital could make up its own definition and justification when determining nurses' pay. Although it is important to point out that the case study hospital was a semi-state-funded one, so the lowest basic salary for nurses was set by the central government.

Despite ongoing policy changes and calls for personnel management reform in Chinese health sector to fully implement 'equal pay for equal work', it is recognised that health authorities and hospital management have not yet able to reflect fairness in nurses' pay. This continues to cause those in service feeling less valued, less satisfied, and more likely to leave the job. Less than a fifth of the nurses in this study thought the bonus scheme was fair. It is difficult to see how bonus was used to encourage productivity or to award performance, but instead, raised concerns of equity and job dissatisfaction, and studies have shown evidence that nurses' job dissatisfaction can link to poor patient care and high job turnover (Liu *et al.*, 2012; Tennant, 2015). It was worrying to hear so many nurses in this study indicating they were not clear about their career prospect, and that they received little career guidance; most nurses were unsure about their career development and employers seldom had supporting policies. What was equally concerning was that people saw nursing as an occupation that did not require technical skills and, therefore, should receive low pay. Over a third of the nurses in this study thought about leaving their work and nearly a fifth indicated that they really wanted to leave; and a shocking 56% said they would not choose to be a nurse again.

By examining the nature of the profession, changes in terms of management and training, and the nature of the work situation, this study has found that the current system used in many Chinese hospitals for nurse education, recruitment, training and development, and pay have not helped establish realistic expectations of nursing or rewarded nurses for the work they do effectively. When two nurses performing the same task but paid differently merely because one joined at a time when permanent contract is no longer the norm, it should therefore not be surprising why so many nurses did not see a way forward in their career. Generally, like any other professions, despite quality of the work and status of the profession, nurses are fundamentally paid workers that are subject to management control, and exhibit all the characteristics of other workers.

I am aware of the limitations of the study, largely due to the limited resources and time allowed for a PhD project. I would have liked to interview more nurses from a list of hospitals to strength the findings of this research. It would have also been better if all nurses from the chosen hospital were surveyed to present a non-selective sample group. Should I get the chance to do more research, I would like to distinguish between line-management and hospital management as employer, and ask questions to test how workers feel towards them as well as how different levels of management shape nurses' views to their job. I would also try to compare with existing findings on their attitudes towards management.

The scale of this study is restricted by the time restrictions of a PhD project. Nevertheless, the 330 nurses who took the time to share their view and feelings have echoed the existing known issues within the management of a nursing workforce. With the increasing demand in health care in China and the growing middle-class population that insist on receiving the best care, the Chinese personnel management system needs to fundamentally assess how a modern nursing workforce is managed from the minute they choose to study nursing. Only with a fundamental change in policy and an enforcement to treat all nurses equally for the work they do can China escape the more serious risk of a nursing shortage, and provide safe and timely care to its people.

This study is a unique attempt to uncover some of the relevant factors that affect Chinese nurses' attitude to and at work. It is a massively under-researched area. The importance of this study is demonstrated through the insights into the motivations and attitudes of the Chinese nursing staff. It also highlighted the under-researched area of Chinese nursing staff, whether it is their pay or their career development. It offered some rational to the acute nursing shortage problem in China – being not more people taking up nursing or nurses' decisions to leave nursing. The findings of this study provides significant evidence which suggests that pay is a relevant factor which affects Chinese nurses' attitudes to work. However, building on from this research, further study is required to determine whether nurses' pay and bonus pay are the main determinants of their attitudes to their work.

To conclude, this thesis is aiming to uncover some of the relevant factors that might contribute to Chinese nurses' attitudes to and at work. By examining the nature of the profession, changes in terms of management and training, and the nature of the work situation, this study has found that nurses' attitudes to the general terms and conditions of work, including pay, bonus pay, training and management control all contribute to how they feel about their work. The study also looked at the relationships in nurses' working life, including nurses' relationship towards patients, co-workers and management, and found that such relationships have some impact on how nurses feel about their work and about the nursing profession. However findings suggested that although nurses were not happy with their pay and some claimed they were unfairly treated, they still performed their duties when at work and did not let any of the negative attitudes they had towards management, co-workers or patients affect their ability to care for the sick. Like any other professions, despite quality of the work and status of the profession, nurses are fundamentally paid workers who are subject to management control, and exhibit all the characteristics of other workers.

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Appendix A Questionnaire

Chinese Nurses' Attitudes towards work Questionnaire

About the Questionnaire

Dear nurses：

Thanks for taking time to read this questionnaire.

This questionnaire is to help my PhD research at Wolverhampton Business School. I would be grateful if you could spare some time to fill it in.

The questionnaire is anonymous. There is no right or wrong answer. Please choose one and only one answer for each question that best describes your situation.

5 is strongly agree, 1 is strongly disagree. Please tick the one that describes your situation the best.

5 - strongly agree; 4 - agree; 3 – don't know; 2 – disagree; 1 – strongly disagree.

Thanks again for your kind help!

Best regards

Feifei Feng

Wolverhampton Business School

1. Attitudes towards nursing

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	you like nursing.					
2	nurses have high social status.					
3	nurses' contribution to society is invaluable.					
4	you are happy when you are working.					
5	your work is difficult and there's always a lot to do.					
6	you work very hard.					
7	you feel pressured because of work.					
8	you feel stressed when at work.					
9	you feel bored when at work.					
10	you have enough time to finish the work you are assigned to do.					
11	you fully understand your work responsibilities and targets/goals.					
12	the work you are doing is challenging.					
13	you are satisfied with your work and it's worth it.					
14	you take on a lot of responsibility at work.					
15	you feel distracted at work.					
16	your skills are brought into full play.					
17	you have enough skills and techniques to do your job.					
18	you have enough confidence to do your job.					
19	you know where to get the information you need at work.					
20	you are happy with your working hours and overtime policy.					
21	you are satisfied with your annual leave.					
22	the hospital recognises the work you do and your contribution to its operations.					
23	you feel a sense of achievement from your work.					

2. Attitudes towards co-workers

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	your department works very efficiently.					
2	you are a member of the team.					
3	everyone in your department works together and you have a high morale。					
4	you have a harmonious working relationship with your colleagues.					
5	in your team, everyone's workload is equal.					
6	everyone has a good working relationship in your team.					
7	you and your colleagues work together to reach targets and to finish tasks.					
8	when at work, you communicate with your colleagues smoothly and on time.					
9	you have lots of disagreements/conflicts and misunderstandings with your colleagues.					
10	there is a lot of competition between colleagues.					
11	you can express your thoughts and opinions freely at work.					
12	you colleagues respect your opinions and feelings.					
13	your colleagues will give you special support and help if you meet difficulties at work.					
14	you help other colleagues when you have finished your work.					
15	you are a member of the hospital.					

3. Attitudes towards management

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	management in your department is fair, equal and open.					
2	Managers in your department have a good working relationship with the staff.					
3	your line manager treats everyone equally.					
4	your line manager has very high professional nursing skills.					
5	your line manager can assign tasks fairly.					
6	your line manager pays attention to your opinions and suggestions.					
7	your line manager understands what you do and how you perform at work.					
8	you are very willing to communicate with your line manager.					
9	your line manager completely trusts you.					
10	you meet your line manager regularly.					
11	you enjoy working with your line manager.					
12	your line manager praises and encourages you when you are making progress.					
13	Your line mangers praises you when you make achievements.					
14	your line manager will give you support and help if you meet difficulties at work.					
15	your line manager will most certainly help you if you need it.					
16	you trust your line manager completely.					
17	your line manager gives you enough support.					
18	your line manager criticises you a lot.					
19	your line manager can resolve all the conflicts at work.					
20	your line manager can help you improve your work skills and abilities.					
21	you feel that your line manager respects you.					
22	your attitude and enthusiasm towards work is affected by how your line manager treats you.					

4. Attitudes towards patients

To what extent do you agree that...

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	you have a good harmonious relationship with your patients.					
2	you are always very enthusiastic to help patients.					
3	you feel sympathetic towards patients.					
4	you are polite towards patients.					
5	you answer all patients' questions politely.					
6	you sometimes chat with the patients.					
7	patients recognise your hard work.					
8	your work is very important to patients' recovery process.					
9	patients rely on you to look after them.					
10	you feel respected by the patients.					
11	patients are cooperative when you are doing your work.					
12	patients have lots of requests.					
13	patients can be very rude.					
14	you have enough time to look after every patient.					
15	patients' family members give you presents in exchange for better care of their family.					
16	you know the different needs different patients have.					
17	you have too many patients to look after.					
18	you can choose which patients you look after.					

5. Attitudes towards pay and bonus scheme

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	given the work you are doing, you are being paid fairly.					
2	you are being paid fairly within the hospital.					
3	you understand how pay is decided in your hospital.					
4	you are satisfied with your pay					
5	your hard work is reflected in your pay.					
6	you are satisfied with your annual pay rise.					
7	the hospital's bonus scheme is fair.					
8	your department's bonus scheme is fair.					
9	your department's bonus scheme is open.					
10	the current bonus scheme is unfair.					
11	the harder you work, the more bonus you receive.					
12	you receive various benefits and allowance during holidays and festivals.					
13	you live a simple life because your pay is low.					
14	you can disagree with the pay you are being offered.					
15	you can talk to your line manager about your pay.					

6. Attitudes towards training and development

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	the hospital provides you with regular professional nursing training opportunities.					
2	you have training opportunities every year.					
3	you have attended at least one training course during the last 3 years.					
4	the training course you have been on is very helpful for your work.					
5	you can ask your line manager if you want to go on a particular training course.					
6	you would like to have more training opportunities.					
7	your line manager decides what training you should have.					
8	all training opportunities in your department are allocated by your line manager.					
9	you feel that you need regular training to improve your nursing skills.					
10	your colleagues have many training opportunities.					
11	training opportunities are always given to colleagues who have a closer relationship with the boss.					
12	there is a dedicated person who gives your advice on career development.					
13	you have made progress in your work skills and gained more experience during the last year.					
14	the training opportunities you have been provided with have helped your life greatly.					
15	you are fully aware of your personal development opportunities and direction.					

7. Attitudes towards career development

To what extent do you agree that…

Number	Question	Answer				
		Strongly Agree 5	Agree 4	Don't know 3	Disagree 2	Strongly Disagree 1
1	you are interested in what you do and it's suitable for you.					
2	you will choose to be a nurse again given the chance.					
3	being a nurse is your ideal job.					
4	you have full confidence in your career development.					
5	working in your hospital is very beneficial for your personal development.					
6	you hope you can carry on working in your department and in the hospital.					
7	you have thought about leaving the hospital.					
8	you really want to leave the hospital.					
9	your job gives you plenty of security.					
10	you are worried that you'll lose your job.					
11	you are fed up with your job, so you want to change your career.					
12	you often speak to people about your work stress and trouble.					
13	career development opportunities are always given to people who are the most suitable.					
14	career development opportunities are always given to people who have a closer relationship with the boss.					
15	your family understands and supports what you do.					
16	work is a small part of your life.					
17	your life is all about work.					
18	you can leave your job anytime.					
19	you are completely devoted to your current job.					
20	there's a big conflict between your job and your personal life.					

1. Anything you want to add or say?

Appendix B Interview questions to the head of hospital

1. Does the hospital have enough nurses? Where do you recruit nurses and are there any special requirements or qualifications needed for the job?
2. Can you explain how nurses' pay is determined? How often is it evaluated?
3. Does the hospital have to completely follow government procedures and rules when determining nurses' pay grades? Does the hospital have any say in the determination process? Do you agree with it?
4. Do you think they are paid fairly? Based on what do you think so?
5. What is the biggest challenge for the hospital when determining nurses' pay?
6. Are there any there issues with nurses' pay that you are aware of?
7. Why is there a bonus scheme for nurses? What are the benefits for the hospital?
8. Has the bonus scheme motivated the nurses? Has it improved productivity?
9. Do you think nurses are happy with their pay? Does that affect their performance at work?
10. How is the hospital managed? Do you think it is well-managed?

Appendix C Interview questions to the head nurse

1. Does the hospital have enough nurses? Where do you recruit nurses and are there any special requirements or qualifications needed for the job?
2. Can you explain how nurses' pay is determined? Do you agree with it?
3. Do nurses know how their pay is determined?
4. Do nurses have any say in how their pay is determined?
5. Do you think they are paid fairly? Based on what do you think so?
6. Do you think nurses are paid enough to be motivated?
7. Can you tell me about the bonus scheme in the hospital? Are all the nurses in the hospital eligible for this bonus scheme? If not, who are eligible and why?
8. Why is there a bonus scheme? Do you think this bonus scheme serves its purposes? Why or why not?
9. What are the problems of the current pay structure and why?
10. How is the hospital managed? Do you think it is well-managed?
11. How is nurses' performance monitored and managed? Are there any difficulties in terms of managing performance?
12. Do you think nurses are happy with their pay? Does that affect how they perform at work?

Appendix D Interview questions to the head of HR

1. Does the hospital have enough nurses? Where do you recruit nurses and are there any special requirements or qualifications needed for the job?
2. Can you explain how nurses' pay is determined? How often is it evaluated?
3. Does the hospital have to completely follow government procedures and rules when determining nurses' pay grades? Does the hospital have any say in the determination process? Do you agree with it?
4. Do nurses know how their pay is determined? Do nurses have any say in how their pay is determined?
5. Do you think they are paid fairly? Based on what do you think so?
6. Are there any problems with nurses' pay?
7. What is the biggest challenge for the hospital when determining nurses' pay?
8. Why is there a bonus scheme for nurses? What are the benefits for the hospital?
9. Has the bonus scheme motivated the nurses? Has it improved productivity?
10. How is the hospital managed? Do you think it is well-managed?

Appendix E Interview questions to the departmental head nurses

1. Do you like being a nurse?
2. Do you work hard?
3. Do you think you contribute a lot to the hospital?
4. Do you know how you are paid? Do you understand it?
5. Are you happy with your pay?
6. Can you tell me how much you earn each month? Do you know how much your colleagues earn?
7. Do you have to work overtime? Do you get paid for that?
8. Do you think you are being paid fairly?
9. Are you jealous of those who receive higher pay?
10. Do you think your pay can motivate you to work harder?
11. Do you like the bonus scheme? Do you think it's fair?
12. Do you think this bonus scheme has made you wanting to work harder?
13. Do you think management uses bonus to reward their favourites?
14. Do you get jealous if people from other units receive higher bonus?
15. Have you ever been promoted? Have you been promoted recently? Do you think you will be promoted?
16. Do you receive regular training opportunities?
17. Does your manager give you enough support at work?
18. Who would you go to if you were mistreated?
19. Can you leave your job? Do you intend to leave your job?
20. Do you get on with your co-workers? Do you work as a team?
21. Do you think you should be paid solely on the basis of your own performance rather than as a team? Are you willing to help your colleagues if they meet work difficulties?
22. What is your biggest challenge at work?